Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE RANDALLSTOWN HOSPITAL NORTHWEST 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** 3 / 11 / 193 5 1 □ M 2 🕮 F LOUTSIANA 75 Yrs Director 439-46-5941 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 ¥ Yes 2 □ No BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral UNITED STATES 2253 SIDNEY AVE 21230 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 ♠ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify.BLACK 3 Widowed 4 X Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SUPERVISOR PRIVATE 6th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည LEANNA BROOKS FRANK HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2\,2\,5\,3$  SIDNEY AVE BALTIMORE, MD.  $2\,1\,2\,3\,0$ TYRUS NELSON/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State injury or cemetery, crematory or other place)
CHESAPEAKE CREMA 11/26/10 BELTSVILLE, MD Donation 5 Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY we of Funeral Service Licer Sign any AVE. 20002 DC MARYLAND NE WASH or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas Approximate Interval Between shock, or heart failure List only one cause on each line. On and th Immediate Cause (Final wsician/ roso disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Day to force a consequence of been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death g Unknown q | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 autopsy perform death? 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 24 hours after death Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of promination and/or invention in a stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 2 only one 29b. Signature and the of c 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DARNELL GLIVER 20:08 4 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 21201 Balt Maryland Med. Ctr Baltimore NO University If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F (Month, Day Months Days Hours 100-40-8708 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ✓ Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Completed by 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 18. Mother's Name (First, Middle, Maiden Sur မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodlawn 4 Donation 5 Other (Specify) Signature of uneral Service Li 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition h sician/ CARDID-RESPIRATORY Medical resulting in death) Due to (or as a consequence of) Examiner EPATO-RENAL Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner IVER Due to (or as a consequence of): Ite patitis IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by ADAVERIC RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should it. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital Other: 2 🗌 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 L Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062148 rection 11/28/2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #3I, Bultone. GENDON 300 Armor. PL 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 William Lee Oldaker Αм November 9:04 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 117 Glider Drive Middle River Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1**3√23**M 2 □ F Days Hours Min. 02/06/1947 Maryland Director 219-46-0640 63 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a Funeral 117 Glider Drive 21220 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1XXYes 2 No 1966-Black. White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 1968 Specify: White Completed 3 
Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Worker Auto Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis H. Oldaker Marie V. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Walker (Cousin) 73 East River Street, Waterloo, New York 13165 or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Holly Hill Mem. Gard. 11/26/2010 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
Bruzdzinski Funeral Home, Mary 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Atherorderotic Cordievasculas nikase Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed ns certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has it completed filled in by the funeral director, page 2.8 completed filled in by the funeral director, page 2.8 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Avatural 2 Accident 3 Suicide work? 1 🔲 Yes 2 🗆 No. 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Milum, W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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32. Regis yar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25 Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner McCulloh Street Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Funeral Days (Month, Day, Year) Hours Min. Country) 1 🔀 M 2 🗆 F Yrs. MD Director 217-66-4571 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore MD NA 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number ò Funeral "natural", or items 23a U.S.A. 21217 McCulloh Street 2331 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian. 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed W Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Air Coil Welder 11th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Irene Covington John C. Porter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) Langford Road, Baltimore, Md 21217 Michael S. Porter-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 12/4/2010 Woodlawn, Md Donation 5 D Other (Specify) King Memorial Park 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses Baltimore, 300 Wabash Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician dbe detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? this certificate has page 2 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation after death Director: / Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination arrays investigation, in my spatial, and the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the Date signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17 AM 2 OI O Physician/ Ralph A. Purnell-El Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAMARITAN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 61 216-50-0353 MD Director Usual Residence of Decedent 10d, Inside City Limits items 23a or 28a-f shov ier must be notified at 10b. County 10c. City, Town or Location 10a. State Funeral Director 1 Yes 2 No **Baltimore** n/a 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21206 3711 Pinewood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married P. Completed by Specify: African-American 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Imput input in the Z7 is marked other than "natur any input or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Astra Zeneca **Factory** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည be Doris Crane Daniel Panniell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2303 Monticello Road, Baltimore, MD 21216 Iris Vennie/Sister 20b. Place of Disposition (Name of cemeters, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Baltimore, MD 11-30-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility While Fine all lone P.A. of Baltimore Co. 21. Senature of Funeral Service License ando 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death RENAL DISEASE Physician/ STAGE END disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ORONARY Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a a | | Ilnknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) e B 12 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No  $5 \square$  Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29b. Signature and title of certifier 29c. License number RES 000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NANDINI YADAY 5601 LOCH 5601 LOCHRAVEN BLVD BALTIMORE 31. Date filed (MDE Cay, Ceal) 2010 2. Registrar's Signa State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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rsicia	an a	Registrar     Decedent's Name (First, Middle, La				Death	2. Date of Death	r <sup>Day</sup> 4, 201	3. Time of Death 5:25 AM N
ledic	al	Barry L. Peres					1		
amin	er	4a. Facility Name (If not institution, giv Manor Care Dul			4b. City, Town, or Towsor	Location of Death		4c. County of De Balt	imore
eral ctor		5. Social Security Number 6. S	Sex 7. Age ( <i>In yr</i> s. 15 M 2 □ F 65	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 6,	Year) 9. E 1944 N	sirthplace (State or Foreig Country) ew Jersey
		Usual Residence of Decedent  10a, State 10b, County	10c Cit	y, Town or Lo	cation				10d. Inside City Limi
ad at	5	10a. State 10b. County		Baltimo					1√2 Yes 2 □ N
Jottifie	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
t pe		2628 Spring Road			21	234		USA	
event, the Medical Examiner must be notflied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 211 No	lispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, W	nerican Indian, hite, etc. white
dical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor.	king	16b. Kind of Busine	ss/Industry
e Me	d d	Elementary/Secondary (0-12)	College (1-4or 5+) 4		esman/man		İ	chemical	company
ant, #	ပိ	17. Father's Name (First, Middle, Las.		Jare	Smarry marr		ne (First, Middle, M		Company
of Health and Men f Item 27 Is marke r other traumatic	To Be	Harry Peres			Anne I	Ruben			
		19a. Informant's Name/Relationship  Judy Peres/spous		1	ng Address (Street Spring			, City or Town, State	e, Zip Code)
		20a. Method of Disposition  1  Burial 2  Cremation 3  4 Donation 5 Other (Speci	Date	20c. Location - City	or Town, State				
any injury o		21. Signa Life of Funeral Service Lice Ronal d. S.	- Ad		2. Name and Addre State Ana Baltimore			Baltimon	re Street
ian ical		23a. Part. Enter the disease, or cor shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the dealy one cause on each line.  a.  Due to (or as a consect	th. Do not en		ng, such as cardiac elliths nosis		est,	Approximate Interval Between Onset and Death
s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23d. Date of Month					
or use a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5t	Other (specify)				Day Year
be detached for use a	by		9□Unknown			ven in Part I.			e to the cause of death?
should be detached for use a	by	9 ☐ Unknown	9□Unknown			ven in Part I.	1 ☐ Y 24a. Was a autop	res 2 No 3 an 24b. Wern	e to the cause of death?  Probably 4 Junkno e autopsy findings availa to completion of cause of
should be detached for use a	Completed by	9 ☐ Unknown  Part II. Other significant conditions  25. Was case referred predical	9□Unknown  contributing to death but not re-		underlying cause gi	26. Place of De	1 □ Y  24a. Was a autop: perfor 1□ Yes  ath (Check only or	an 24b. Wern prior deat 2 No 1 1	e to the cause of death?  ] Probably 4 Sunkno e autopsy findings availa to completion of cause of the cause o
should be detached for use a	To Be Completed by	9 ☐ Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	9 Unknown  contributing to death but not read the second of the second	sulting in the u	underlying cause given the control of the control	26. Place of De	1  Y  24a. Was a autop: perfor 1 Yes  ath (Check only or Home 5  Resid	in 24b. Wern prior deat 2 22 No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e to the cause of death?  ] Probably 4 Eunkno e autopsy findings availa to completion of cause of the cause o
should be detached for use a	To Be Completed by	9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 Vo  27. Many of Death 1 Natural 5 Pending investigati	9 Unknown  contributing to death but not resemble to the second of the s	ER/Outpatie	underlying cause givent 3 DOA Otto	26. Place of De her: 4 Nursing h iry at rk? ] Yes 2 □ No	1 □ Y  24a. Was a autoputor 1□ Yes  ath (Check only or  Home 5 □ Resid  28d. Describe h	an 24b. Wern yer of deat neb 2	e to the cause of death?  Probably 4 Unkno e autopsy findings availa to completion of cause of the cause of t
should be detached for use a	Certification: To Be Completed by	9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No  27. Many r of Death 1 Natural 5 Pending investigati 2 Accident 3 Suicide 6 Could not determine	9 Unknown  contributing to death but not reconstributing to death but not reconstruct the second sec	ER/Outpatie  28b. Time Injury  nome, farm, st	anderlying cause given to a property of the pr	26. Place of De her: 4 Nursing h ury at rk? ] Yes 2 \( \) No	1 ☐ Y  24a. Was a autop: perfor 1☐ Yes ath (Check only or Home 5 ☐ Resid 28d. Describe h  28f. Location (S City or Tow	an 24b. Wern prior deat 2 2 No 3 and prior deat 2 2 No 1 and ne) lence 6 Other (Street and Number of the Street and Numbe	e to the cause of death?  Probably 4 Dunkno e autopsy findings availa to completion of cause on? Yes 2 DNo  Specify)  r Rural Route Number,
je 2 should be detached for use a	To Be Completed by	9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No  27. Many r of Death 10 Natural 5 Pending investigating and solicide 6 Could not determine	9 Unknown  contributing to death but not resemble to the second of the s	ER/Outpatie  28b. Time of Injury  nome, farm, sl	ent 3 DOA Otto	26. Place of Denher: 4 Nursing Harry at Trk?  Yes 2 No	24a. Was a autop. perfor 1 Yes ath (Check only or Home 5 Resid 28d. Describe h	an sy 24b. Wern sy	e to the cause of death?  Probably 4 Unknown e autopsy findings availat to completion of cause of Press 2 13 No  Specify)  r Rural Route Number, or as stated.

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2010 Medical Thomas John Powers November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center for Hospice Towson 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. (Month, Day, Ye **Director** Wisconsin 217-26-7275 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Essex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 504 North Stuart Street S. Α. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1943 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 1946 White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 /C & Heating Technician Steel Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Powers K. Francis Anna Lauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) orraine Sunder (Daughter) Airville, Pennsylvania 17302 228 Crowl Road Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complication at a caused to edeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final MOTASTATIC Physician/ ManxHC Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been sinned by the managed of the control of the Funeral Director. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Other (specify) Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No autopsy performed Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury atural work? 1 Yes 2 No Accident Investigation

Division of Vital Records,

completed filled in by the State

Registrar

DHMH 17 Rev 7/2009

Medical

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check

only one) 29b. Signature and title of certifle

Could not be

determined

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

046360

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number.

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15, Month 4:30 PM M **Physician** 2010 November Florence G. Potrzuski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Presbyterian Home 9. Birthpface (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Yea Aug 18, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number Min. **Funeral** Days Hours 1924 1 □ M 2 🔽 F 86 Director 218-14-8413 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State r than "natural", or Items 23s or 28s-f show the Medical Examiner must be nutited at 1√2 Yes 2 □ No Funeral Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 705 Rose Street of filed within 72 hours after death in Hygiene.

Other than "natural", or Items 23 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 27 No f Yes, Give 1 Never Married 2 Marned Specify: white 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 🎇 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 0 housewife own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fitted. Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event. Wanda Litwinski Joseph Knasiak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 76 Haverhill Road Joppatown, MD 21085 Janet Jelen/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Fune al Service Licensee Konald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD arr 21201 Pert | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sugathe Heart **Physician** /Medical Due to (or as a consequence of): Figuration **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown sertension Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an this certificate has ral director, page 2 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No ပို To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Kenseth M. Greeke

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles Sh.

29c. License number

037016

Sa. Je 4/109

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a Per FH G910 12/01/10 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical t and number) Town, or Location of Death 4c. County of Death me (if not institution, give str **Examiner**  Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 24 Hrs 8. Date of Birth **Funeral** Min (Month Day, Months Hours Yrs Director 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director Examiner must be notified 1 Yes 2 No more 10f. Zip Code 10g. Citizen of What Country? ò 10e Street and Number 23a Funeral death with LZerne Was Deceud.
Armed Forces?
Yes 2 No or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me ife. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be Name (First, Middle, Maiden Father's Name (First, Middle, Last) ပ City or Town, State, Zip Coden 1 206 Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 21. Signature of Funeral Services icenses ervices 21 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): use as the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after det th. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year ξ 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the a 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 1 🗆 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗷 Natural work 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the D rector 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at er de To the Funeral D recto completed filled in by the determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 [ 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2010 71040 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NE Pa 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month November Physician/ Day 23 2010 02:58 AM Francis Richard Robinson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Feb. 23 Days Min 1 ፟ M 2 ☐ F 73 Yrs. **Director** 214-34-6059 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🙀 No Odenton Maryland Anne Arundel 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 21113 USA 583 Rita Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces' Black, White, etc. þ 1 Never Married 2 Married Yes Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Glve kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Military US Armed Services Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Francis Robinson Hazel Leggett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 583 Rita Drive, Odenton, MD 21113 Delores Robinson (spouse) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Dec 01 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemi 2010 Crownsville, Maryland Stallings Funeral Home, P.A. of Funeral 22. Name and Address of Facility 21. Sign 3111 Mountain Road, Pasadena, MD 21122 ons wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Part 1. Enter the disease, or comp shock, or heart failure List only or Approximate 23a. Part 1. Enter the dis Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Head and Neck Cancer years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deetached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 ompleted filled in by the funeral director, page 2. performed?

☐ Yes 2 🔯 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospice House examiner? Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\boxtimes$  Other (Specify) 1 ☐ Yes 2 🖾 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D31551 November 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell Deluc 305 Hospital Drive, Glen Burnie, MD 21061

State Registrar Date filed (Month, Day, Y

32. Regi

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 26 Jocelyn G. Redmer 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Franklin OSC da la Juder 1 Year | If Under 24 Hrs. +, more Square HOS Under t 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 🔀 F **Director** 217-16-6997 83 April 8,1923 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantime rough to rediffed at 1 □Yes 🏋 □ No Director Md, Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "A" Brook Farm Court USA Funeral 21128 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 🛣 No White þ Specify: 3 X Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Kennard 2 Leora Boykin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Redmer, Sr. Son 5009 Cameo Terrace Perry Hall, Md. 21128 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Michael Cemetery 12-2-2010 Balto. Md.
22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Fire al 5 year ensee 9705 Belair Road Nottingham, Md, 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to for as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumonio Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) be detached 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown , page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check onl

Hospital or Attending 24 hours after deat Funeral Director: completely the within To the

Joce 14

Redmer

State Registrar one)

d title of certifier

MIAM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KVIMER

29b. Signatu

DHMH 17 Rev 1/2001

29c. License number

Franklin Square Drive

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#5 Per FH G911 1/06/2011 Jh

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05:10 AM Paul William Ruppert 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Franklin Square Hospital Center Rosedale 5. Social Security Number 215–54–2940 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
December 4,1953 Maryland Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Min. **Director** 56 Usual Residence of Decedent non 41 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** Md. 1 ☐ Yes X☐ No Balto. Perry Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9608 Amberleigh Lane Apt. 21128 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 🗆 Yes 2 🏝 No White Specify: Rupert, 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education \_D1116 Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is meany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 George G. Ruppert Lydia Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 9608 Amberleigh Lane Apt "M" Perry Hall, Md. Angela Ruppert 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Parkwood 11=30-2010 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licens Schimunek Funeral Home 22. Name and Address of Facility 100 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Multiple organ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed?
☐ Yes 2 ☑ No 2 - No 1 TYes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 Y No Other: 잍 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 29c. License number RES 00000 WI 11-26-2010 person who come leted cause of death (Item 23a) (Type, Print) Richard Lai, MD. 9000 Franklin Square DR. Baltimore MD. 21237 31. Date filed State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30 2010 Physician/ 3:00 am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** ARNOLT ANNE ARUNDE If Under 1 8. Date of Birth 9. Birthplace (State or Foreign Year If Under 24 Hrs. Social Security Number **Funeral** Days 1 □ M 2 💆 Months Min. JARYLAND 220-12-452 Director 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Completed by Funeral Director ms 23a or 28a-f s must be notified ARNOLD 1 Yes 2 No 10g. Citizen of What Country? 5-A. 21409 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WhITE 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ RNARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHERINE, REMETRAS, DAL 714 Hiltop B. Opchard BEACH, MD. 21226 : If item 2 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTO. NATIONAL CEMETERS. Method of Disposition Date permit. Page 1
Department of Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) M00942 2601 Mour et caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final Physician/ ignant Imonth disease or condition Medical resulting in death) **Examiner** unknown Cane Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 Yes Division of Vital Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 50725 ND who completed cause of death (Item 23a) (Type, Print) nniter State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2010 Vivian Roby Reio 1:52 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Days Min Feb. 21, 1933 Hours 578-42-3329 77 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Jessup 1 Yes 2 X No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9950 Guilford Road, Apt. 318 20794 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: white Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Data Entry Key-punch operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Guy M. Roby Edna Louise Whip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Green, Jr. / Son 2821 Glen Isle Road, Riva, MD 21140 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Nov. 4 Donation 5 Other (Specify) St.John Epis.Cemetery 2010 Beltsville, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Ken Skils M01053 313 Talbott Ave., MD 20707 Laurel, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Stroke Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 X N 1 \sum Yes 2 🔀 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 x No 1 Tyes 1 XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Within 24 hours after www...

To the Funeral Director: After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License numbe November 23, 2010 D50987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed, Nawaz, MD, 1500 Forest Glen Road, Silver Spring, MD 20910 32. Registrar's Signal State Registrar

## VOID

## CERTIFICATE #

2010-37515

## SEE

# CERTIFICATE #

2010-40593

Decedent's Name - Claudia E. Russell DOD 11/23/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onstance Elmii		ussell St 1-For State Registrar	ate of Maryla		epartme Ce <i>rtifica</i>			nd M	ental Hy	ygiene '	Reg. No.	201	0	37516
Physicia Nedical Exami	an/	Decedent's Name (First, Midd		NSTAN	ICE EI	LMI	RA RUS	SEL	L	2. Date of De Month Novembe	Day	Year	;	3. Time of Death 1505 hrs
		4a. Facility Name (if not institution 142 Dunlap Road					b. City, Town, o	or Locat				County of I		
Funeral Director		5. Social Security Number 213 36 4361	6. Sex		yrs. last birth	day) Yrs.	If Under 1 Ye		Jnder 24Hrs. ours Min.	8. Date of 8		1	9. 8irth Cour	place (State or Foreign htry)
nd show any ice.	_	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arundel		city, Town o				_				1	10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f show ist be notified at once.	Director	10e. Street and Number  142 Dunlap	Rd.				10f. Zip Code	21	122		10g. Cit	izen of What		y?
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she remmatic event, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 M	arried 12. Was Dec Armed For 1 Yes	orces?		If Ye	S Decedent of Hes, specify Cuba	an, Mexi	can, Puerto		lo-	14. Race - / White, e	etc.	ite
36 in 72 hours af han "natural' lical Examin	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	lor Dates: cify only highest grad	de complete	- du	ecedent uring mo	's Usual Occup ost of working lif	ation (G fe. DO N	ive kind of w			Kind of 8usir		dustry staurant
nore, MD 21215-0036 ages I and 2 should be filed within 72 art of Health and Mental Hygiene. It If Item 27 is marked other than other fraumatic event, the Medical	Be	17. Father's Name (First, Middle	Jose	ph Al	lison	n P	rior	18. <b>M</b> o	argai	(First, Middle,	, Maiden W∈	Surname)	ser	
MD 21 td 2 should alth and Me m 27 is ma aumatic ev	٩	19a, Informant's Name/Relations Debbie Riese			r   10	066	Address (Stre Vena	Lan	e Pa	asader	na,	MD :	211	22
Baltimore, MD 2 pemit. Pages I and 2 shoul Department of Health and I Important: If item 27 is re injury or other traumaric		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other S		om State	cremator	ry or oth .eW	tion (Name of c er place) Crema	tory	11/		В		ore	e, MD
		21. Signature of Funeral Service 23a. Part I. Enfer the disease, or		ayand the d	eath Danet	16	9 Rivi	era	Driv	ve Pa	asac	lena,		Home, PA 21122 Approximate Interval
Physician Examiner	(4)	failure. List only one ceuse Immediate Cause (Final disease or condition resulting in death)	on each line.	ensive	athe									Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a	consequen	ce of):									
cecuted 1 and - transit		events resulting in death) Last	Due to (or as a											
O, be es sician	Medical	IF FEMALE:	23c. If yes,	outcome of p	per M	E g	10 12/				23	d. Date of de	livery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional page 2.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month  4 Pregnant at time of death 5 Other (Specify)  9 Unknown								Da	y Year			
ires that the disagned by the	۵	Part II. Other significant condit			•		, ,	•	Part I.		_			e cause of death?
of Vital Records, ng Physician: The law require wher this certificate has been simeral director, page 2 should be	Completed	<u>Diabetes me</u>	llitus; N	ose Bi	leedin	g				24a. Was auto perfe 1 Yes	psy ormed?	prio dea	r to cor	psy findings available npletion of cause of
Vital Rec hysician: The this certificate I director, page	To Be (	25. Was case referred to medica examiner?  1 ✓ Yes 2 No	Mary State and	Inpatient 2	P ER/Out	patient	_	-	ath (Check o	nly one) Home 5	Reside	ence 6 🗸	Other: S	Scene
tion of tending Ph death.	ation: T	27. Manner of Death  1 X Natural 5 Pend	ding stigation	, Day,Year)		me of In	1	jury at W Yes 2	☐ No	28d. Describe				
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.  4 Homicide  29a. Certifier 4 Coefficies Physician To the back of my keep ladge, death accurated the time date and place, and due to the course(s) and manager as stated.												
To the Hospital within 24 hours. To the Funeral completely filled	edica	(Check only one) 2 ✓ Medical Exa	hysician: To the bes miner:On the basis of and manner s	of examinati	-		on, in my opinio	on, death	occurred at		e and pla	ace, and due	to the	cause(s)
		29b. Signature and title of certifie	ف ، و	r		_	29c. Licen	.M.E.	per			Date signed rember 10		
			nt Medical Exar	miner 1	111 Penn		t, Baltimore	, MD 2	1201					
St Regis		31. Date filed (Month, Day, Year)	2010 32. Re	gistrar's Sig	nature	Ma	ale							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November<sup>Day</sup>27,2010 6:40P.M Rutkowski Physician/ Genevieve Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Baltimore Towson Gilchrist Care Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) MacryTand Days Min **Funeral** 1 🗆 M 2 🖾 Months Ma\v1'0\pay1\g'23 87 220-07-2781 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director 1 Yes 2 No Dundalk Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21222 Funeral 6821 Boston Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ģ 1 ☐ Yes 2 № No Specify: Specify: White Baltimore, Maryland 21215-0036 If Yes, Give 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Martin Marietta Upholster 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Josephine Szewczyk 2 Max Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5928 Snowdens Run Road Sykesv<u>ille,Md21784</u> Andrea Castillo-Daughter December 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cemetery, crematory or other place)
Sacred Hrt of Mary 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1, 2010 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service L 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cor pulmmale months Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner embilisa noth: Sequentially list conditions le to (or as a consequence if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and do be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IE EEMALE 23d. Date of delivery . If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown hear t peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 s perforn 2 🗌 No ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be funeral director, examiner? Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No ျ After this 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27 Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. Investigation Accident within 24 hours after death

To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

3 [

re and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signat

6701 N-(

29c. License number

harres

29d. Date signed (Month, Day, Year)

NULLOT

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 02122 PM D'Nae Ayana 17 Stepteau-Baker November 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Hospital Saint Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F Days Director 214-19-0746 33 01 07MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Y☐Yes 2☐No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 154 South Collins Ave 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2yrs lementary/Secondary (0-12) 12th grade Self Employed Manicurist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Stepteau Linda Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau South Collins Ave. Baltimore, Md 21229

sposition (Name of Date 20c. Location - City or Town, State Daniel Baker-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 12/3/2010 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Signature of Funeral Service Licenses Wabash Ave, Baltimore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) Disseminated Cervical Carcinoma 7 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for i Day Year 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ed Completed stepteau Renal 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending Patter death.

I Director: After d in by the funera 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P25479 Mershayer November 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMENEH MASHAYEKH, 900 South Caton Avenue, Baltimore, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month NOV. Day 2010 Year Physician/ 28 10:12 P. M Roy Clifton Stroman Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore 1605 Gorsuch Avenue 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Days July 27, 1956 Mary Tand Hours 219-66-7387 **Director** Usual Residence of Decedent should be filed within 72 hours and the should hard Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show arked other than "natural", or items 25a or 28a-f show arked other the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10h County Yes 2 No Baltimore N/A Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21218 USA 1605 Gorsuch Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Mever Married 2 ☐ Married Specify: Black δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Warehouse Laborer 11th grade other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Virginia Ruth Stroman Willie B. Miller, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tran 2245 E.Biddle Street Baltimore, MD 21213 Horace Miller/Brother 20a. Method of Disposition

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/02/2010 | Lansdowne, MD Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ancreatic Conver- Inoperable immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner HIV - COC CHI B-3 Sequentially list conditions, Due to (or as a consequence of): Examine or any, leading to immediate cause. Enter Underlying Hepatitis C To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ☐ Live Birth ∠ ☐ Fee. ☐ Pregnant at time of death in the past 12 months? Month Day g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Depression 24a. Was an autopsy performed? Yes 2 K No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner?
1 Yes 2 No Other: 4  $\square$  Nursing Home 5 Residence 6  $\square$  Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Exhaut R. Von Duenen, MD 0065990 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Eduardo

31. Date filed (Month, Day, Year)
DEC 0 1 2010

R. Lein Guerrero, mn

1001 Cathedral St. Baltinue, Mo 2/201

Registrar

31. Date filed (Month, Day, Year) **DEC 0 1 2010** 

ALBERT

SLITZER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month oly mer November 2010 1:15 PMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 30 Locust Street #604 Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🗓 F Director 219-22-6905 83 18 1927 Mar Maryland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD 1 ☐ Yes 2X No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 30 Locust Street #604 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) secretary electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Marin Nighoff Elizabeth Matilda Schanken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Seymer/son 417 Babylon Court Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Ronald 22. Name and Address of Facility S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ector 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Osuse (Final Physician disease or condition 00/5 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ral director, page 2 s performed 2 🗆 No ☐ Yes 2 🗷 N 1 Tes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

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2010

31. Date filed (M

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Thomas Smith Sr November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min Dec 5. 81 Director 214-26-1794 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 705 Compass Road #417 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) construction truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Benson Smith Annie Danson 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1325 Jervis Square Belcamp, MD 21017 John Smith Jr/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 
Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or host failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Mietristach's non-small will long cancer Medical Due to (or as a consequence of): Examiner Certificate: To Be Completed by Physician/Medical Examiner Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Sequentially list conditions,	t										
if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):										
resulting in death) Last	Due to (or as a consequence of):										
	d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year						
Part II. Other significant conditions of	contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?						
ischemic cardion	mopathy		1 ☐ Yes	2 □ No 3 🗗 F	Probably 4 🗆 Unknown						
			24a. Was an autopsy performed? 1 □ Yes 2 🕅	prior to death?	utopsy findings available completion of cause of						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 🗆 Yes 2 💢 No	Hospital: 1  Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residence	6 M Other (Spec	city) HESPI'C C						
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigatio		1	28d. Describe how inju								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Exam	sician: To the best of my knowledge, death occ iner: On the basis of examination and/or investiga se Practioner: To the best of my knowledge, dea	ation, in my opinion, death occurred at	the time, date and place	e, and due to the	cause(s) and manner stated.						
29h Signature and title of certifier		20a License pumber	00.1.0		( D V )						

6:20 PM M

10d. Inside City Limits

Interval Between

Onset and Death

11 ears

Baltimore MD 21204

white

1 Yes 2 No

State Registrar

Medical

N charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pate

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Charles Grant Se		I- For State	ate of	Maryla		partment of e <i>rtificate o</i>			Mental H		leg. No.	010	37523
Physicia	n/	Registrar 1. Decedent's Name (First, Midd	e, Last)							2. Date of Dea Month	Day	Year	3. Time of Death 1137 hrs
Medical Examin		CHARLES G S	ETTI	LES_	mhos)		4h City	Town or Lo	ocation of Death		r 11, 2010	nty of Death	
)		4a. Facility Name (if not institution Prince George's Hosp		eet and nu	imber)	ŧ	Chev		ocation of Deati			e George	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs	. last birthday)	If Und	er 1 Year	If Under 24Hrs	s. 8. Date of Bi	rth (MM/DD/Y	YYY) 9. Bir	thplace (State or Foreign
Director		577-68-2602	1 X M	2 F		59 Yrs	Monti	ns Days	Hours Min	11/3	0/195	0 WA	untry) SHINGTON I
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5-0036 led within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle	Last)		-					e (First, Middle,		ame)	
215 be filk mtal H rrked o	Be	ROBERT SETTL								E MATT			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations TAMIKA SETTL:			TER	19b. Mailin	g Addres HOW	s (Streeta ARD	and Number or RD SE	Rural Route Nu WASHIN	mber, City or ${}^{\circ}$	Town, State DC	20020
mand 2 sho ealth and 2 rem 27 is traumati		20a. Method of Disposition			20b	D. Place of Dispos	sition (Na	me of ceme		Date			Town, State
Baltimore, MD 2 pemit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		1 Burial 2 Crematio		Removal fr	rom State	crematory or of ERITAGI	ther place	) METE	RY_ 11	/20/10	WALI	ORF,	MD
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Ba Dep Dep Inju		sharon to	Krs.	en s	falle	1 11	125	MARY	LAND A	VE., N	NE WAS	SH.,	DC 20002
Physician		23a. Part I. Enter the dise se, of failure. List only in cause	complication each I	tions that <b>c</b> line.	aused the de	th. Do not enter	the mode	of dying, su	uch as cardiac o	or respiratory ar	rest, shock, o	r heart	Approximate Interval Between Onset and
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·					consequence unt Aneury	, or). /smal Ruptur	e						
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		to (or as a	consequence	of):							
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<b>0,</b> be executed sician and burial - transit	dical	UNPENDED	_ A	MENDED					_				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 14 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tell pittled in by the funeral director, page 2 should be detached for use as the burial - transi	ω,	IF FEMALE: 23b. Was decedent pregnant in t		23c. If yes,	outcome of pre		etal death	3	Ectopic pregna	ancv	23d. Dat Mont	te of deliver	y Day Year
× 68 h certi tendini use as	Physician/M	past 12 months?	. 4		nant at time of	4	ther (Spe		]=				
Box le death of the atten ted for us	hys	1 Yes 2 No 9 Ur	,	9 Unkn					an in Dort I	220 Did	tobacco use c	contribute to	the cause of death?
s, P.O. Bc irres that the des signed by the a		Part II. Other significant condi Chronic Renal Disea		-			underlyin	g cause giv	enm Fait i.				bably 4 Unknown
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of Vital Records, g Physician: The law requir ufter this certificate has been s neral director, page 2 should	nple										ormed?	death?	completion of cause of
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Vital hysician this cert	o Be	examiner?	and the same of the	oital: 1	Inpatient 2	✓ ER/Outpatien	t 3			ng Home 5	Residence	6 Othe	r:
n of \ding Phy h. After the	$\vdash$	27. Manner of Death	_	28a. Date	of Injury Day, Year)	28b. Time of	Injury	28c. Injury		28d. Describe Subject ble			nt runture
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Division ospital or Attendin hours after death.	Certification:	3 Suicide 6 Cou	ld not be			home, farm, stre	et, factor	y, office bui	ilding, etc.	or Town.	State)		ural Route Number, City
D Hospital 24 hours Funeral tely fillec		4 Homicide	rmined		Local Str	edge, death occu	erad at the	a time data	and place and	322 56th Str			
To the Hosi within 24 hd To the Fun completely	Medical	(Check only 1 Certifying Fore) 2 Medical Ex	miner:Or	n the basis	of examination	edge, death occu n and/or investiga	ation, in m	e time, date ny opinion, d	e and place, and death occurred	at the time, date	e and place, a	ind due to th	ne cause(s)
To with	Med	29b. Signature and title of certif		id manner s	stated		29	c. License	number		29d. Date	signed (Mo	nth, Day, Year)
		( Xx bal	Rell					O.C.M	I.E.		Novemb	ber 12, 2	010
, —		30. Name and address of perso								20.4			
)			Assistan		al Examine				ore, MD 212	201			
S Regis	tate trar	31. Date filed (Month Day Kear	1 20	110 32. 8	egistrar's Sign	ature J. A	ark	1					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	partment of Health and Mental Hypertificate of Death	giene Reg. No.2010 37524					
	Physicia		1. Decedent's Name (First, Middle, Last)  John G. Staab, Sr.	2. Date of Dea						
	Medic Examin		4a. Facility Name (if not institution, give street and number)  2509 Ambler Court	4b. City, Town, or Location of Death  Dundalk	4c. County of Death Baltimore Co.					
	Funeral Director		5. Social Security Number 217 - 22 - 0291 6. Sex 1.4 M 2 G F 83 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birt   Months   Days   Hours   Min.   June 1 Organia   1 Organia						
	laryland <b>3a-f show</b> ified at	ector	Usual Residence of Decedent	ocation Dunda1k	10d. Inside City Limits 1 ☐ Yes 2√☐ No					
	with the N 23a or 28 ust be not	<b>Funeral Director</b>	10e. Street and Number 2509 Ambler Court	10f. Zip Code 21222	10g. Citizen of What Country? U.S.A.					
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 L Never Married 2 L Married 1 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☒ No Specify:	14. Race - American Indian, Black, White, etc.  Specify: White					
21215-0	within 72 hou /giene. ner than "natu t, the Medical	e Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12)  8th  College (1-4 or 5+)  Qual	dent's Usual Occupation kind of work done during most of working DO NOT use retired) ity Control Inspector	16b. Kind of Business Industry Crown , Cork, & Seal					
yland	uld be filed Mental Hy narked otf	To Be	17. Father's Name (First, Middle, Last) Edward Adam Staab	18. Mother's Name (First, Middle, Margaret Mary	·					
Baltimore, Maryland 21215-0036		di. 3	Kathy Ann Rostkowski 3723	matory or other place)	1.0					
Baltın	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Kaczorows 201 Dundalk Avenue Ba	ski Funeral Home,PA					
سې ۱	Physician/ Medical Examiner  springle-transit	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Degeneration	est, Approximate Interval Between Onset and Death 5 Yews					
. Box 68/6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year					
ords, P.O.	requires that the been signed by should be deta	by	Pair II. Other significant conditions contribute to the cau							
Vital Records,	n: The law ficate has or, page 2	<b>Completed</b>	25. Was case referred to medical	autop perfoi 1 □ Yes	prior to completion of cause of					
n or vita	nding Physicia tth. : After this cert e funeral directe	cate: To Be	examiner? 1	, 1	lence 6 Other (Specify) ow injury occurred					
UIVISION	tal or Atter rs after deg al Director ed in by th	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)					
	the Hospi thin 24 hou the Funer mpleted fil	Medical	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, death check only one)  1 X Certifying Physician: To the best of my knowledge, death check only one)  2 Medical Examiner: On the best of my knowledge, death check only one)  3 Certifying Nurse Practioner. To the best of my knowledge,	stigation, in my opinion, death occurred at the time, date and death occurred at the time, date and place, and due to the	nd place, and due to the cause(s) and manner stated. e cause(s) and manner as stated.					
D	<b>7</b> . W <b>6</b> . 00		29b. Signature and title of certifier  Colling Churches  30. Name and address of person who completed cause of death (Item 23a) (Type, Colling Christmas, MD 5505 Hopkins  31. Date filed (Month, Day, Year)  11. Date filed (Month, Day, Year)  12. Date filed (Month, Day, Year)	29c. License number D 51/85	November 29, 2010					
			30. Name and address of person who completed cause of death (Item 23a) (Type, College Christmas, MD 5505 Hopkins  31. Date fled (Month Day York)	Bayrien Circle, Balton	nore, Maryland 21224					
	Stat Registra	e ir	DEC 0 1 2010 Person B.	park	•					

DHMH 17 Rev 7/2009

amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20110 37525 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Month 9-2010 Sylvia Jacqueline Teller 12:09 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 8. Date of Birth 1 ☐ M 2 🗓 F Months Days Hours Min 06400924928 82 **Director** Usual Residence of Decedent show 10b. County aţ 10a. State 10c. City, Town or Location Director 10d. Inside City Limits be notified 28a-1 MD Harford Fallston 1 Tes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a edical Examiner must b Funeral 1719 Laurel Brook Rd 21047 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ 🗌 Yes 2 💢 No If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3 🕅 Widowed 4 🗆 Divorced Specify:White Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Benefits Manager Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H 2 Adam Kwiatkowski Antoinette Grabowski injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>. 9</u> permit. Page 1 and 2 st Department of Health a Important: If item 27 is Bonnie Baker (Daughter) 1719 Laurel Brook Rd Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gar. 11-23-2010 Bel Air, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir any Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or linjury that initiated events and resulting in death) Last Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cancer in 2004 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Cther: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) s after death. 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year) injury 5 Pending Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5mn, M. 9) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FALLSTON SUN, M.D 1716 HARFORD ROAD, Suite 105, State Registrar

rease Typ of Print in Black indelible link. Elisure All Copies Are Leg State of Maryland / Department of Health and Mental Hygiene 37526 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 20 10:20 Nov Myrtle Ada Tyrie Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore <u>Parkville</u> Oakcrest Care Center 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number New Jersey Funeral Min. Month, Day, Year 21 Months Days Hours 1 □ M 2 XX 141-21-4344 Director Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 Yes XX No Parkville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Completed by Funeral USA 8810 Walther Blvd 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNO
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married White 1 🗆 Yes 2 📉 Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other traumatic event, the once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Conklin ဥ Grace Ada Harry Vincent Morningstern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8810 Walther Blvd. #3302 Parkville, MD Andrew A. Tyrie (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/24/10 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licen 9705 Belair Rd, Nottingham, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCUD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Day Year in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 2 No 1 Yes of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Yes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: 1 Natural 24 hours after death. Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No Division M Investigation Accident the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide within 24 hours after dex To the Funeral Director completed filled in by th determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05864 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hler 9900 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37527 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13:65 Patricia Banks Thomas Medical 2010 Novembar 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) 1 M 2 TF Hours Country) Director 213-48-1389 57 0 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD NA Baltimore 1X Yes 2 □ No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral "natural", or items 23a Balset Ct 21244 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Completed 3 Widowed 4 X Divorced Specify: Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Howard County Elementary/Seconday (0-12) College (1-4 or 5+) 4yrs 12th grade District Court Clerk District Court of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be filed 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important; if item 27 is marked of any injury or other traumatical 18. Mother's Name (First, Middle, Maiden Surname) မ Ulysses A. Banks Phyllis Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Thomas-Daughter Balset Ct., Baltimore, Md Baltimore, homas 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 🗆 Cremation 3 🗆 Removal from State 1 Burial 2 Cremanon 5 Other (Specify) Woodlawn 12/4/2010 Woodlawn, Sig ture of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av AVA. Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ isease or condition Intra (vania)
Due to (or as a consequence of): Hemorrhage day s Medical resulting in death) Examiner Due or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury 10 years Examine or as a consequence of the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death Month Yes 2 No the g Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed Drabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 N certificate 2 **X** No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune
completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) andy 1658688333 all. November 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Beaudy

1tospital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ Month 1355 Arthur E. Trabert lovember 21,2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbury Rehabilitation + Nursina Ctr. Salisbun Wicomico If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, une 5 Months Hours Min 1 🕅 M 2 🗆 F **Director** 214-18-5347 87 June Maryland Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 200 Civic Avenue 21864 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami Acthur \ CaDart Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 X Widowed 4 ☐ Divorced 43-52 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 supervisor manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Duane Trabert Gertrude Anna Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 1810 Prindle Drive Bel Air, MD 21015 Ronald Wilkens/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) State and Address of Facility and 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ e ea1. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-trans signed by the attending physician and doe detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 € 10 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has page 2 autopsy performed 2 No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 2 1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

20

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19:35 P M Shirley Mae Tuminello November 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 400 Millington Avenue; Apt 320 Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 3, 1931 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday, **Funeral** Days Hours 1 □ M 2√□ F 79 Yrs 216-28-1391 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show event, the Medical Examiner must be notified at 1√2 Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA 400 millington Avenue #320 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 nursing aide healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mae McComes John Fefel ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elain Eisenhardt/sister 35531 Knoll Way Millsboro, DE Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sep ROTTa 1 d Director State and Address Fabluard 655 W. Baltimore Street 21201 Baltimore, MD 2 ia. Part 1. Enter the discussed in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Perripheral Arterial Disease Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Atherosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) 1 □Yes 2 No been signed by the a Ö 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ percholesterolemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Osteoporosis 24a. Was an certificate has be irector, page 2 sl perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 TNo 2 Accident

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a, Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ESEGE

Registrar

State

UNIVERSITY CARE EDMONDSON VILLAGE

Registrar's Signature

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D46071

28f. Location (Street and Number or Rural Route Number, City or Town, State)

EDMONDSON

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time Death Day Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 🛣 M 2 🗆 F **Funeral** Country) NY Months Days Hours Min 03<sup>M</sup>913-1y9<sup>y</sup>2 073-22-2612 83 **Director** Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 603 F Churchill Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?
Yes 2 \sum No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mounted Police Deptment New York City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Caesar Valdata Josephine Poggi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian A. Valdata (Wife) 603 F Churchill Rd Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 11-27-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir Signature of Funeral Service Licer Inc 610 W. MacPhail Rd BelAir, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition aratar Medical resulting in death) Due to or as a consequence of): **Examiner** MAGNIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ę Month Day Year ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5  $\square$  Pending 1 🔲 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.O Boggs 31. Date filed State Registrar

✓ DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3753 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11 -212 - 2010 y Physician/ 0315 A Theresa G. Weglein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth **Funeral** Country) MD 1 □ M 2 🗓 F Hours Min. 06-23-1926 212-22-8252 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No MD Harford Abingdon 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21009 IISA 302 A Tall Pines Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married "natural", or þ 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 🕅 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Homemaker permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked any injury or call Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 9 Herman Berenbrok Catherine Hauser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2502~{sinsko}~{Lane}~{Joppa,}~{MD}~21085$ 19a. Informant's Name/Relationship (Type, Print) Catherine Matthews (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 11-29-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 cut c Myscard Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, Physician/Medical Examiner Due to lor as a consequence of: if any leading to immed cause. Enter Underlying cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant 9 ☐ Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ê 2 **N**0 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Box Hill Corporate Center Dr. Abingdon 31. Date filed (Month, Day, Yea State LEC 0 1 2010 Registrar

DHMH 17 Rev 7/2009

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			For State Registrar	State of Marylan	,	artment of H		nd Mer		iene	0 (	37532
1	Physici		1. Decedent's Name (First, Middle 5 ALLCLE)	WEST					Date of Deat Month	Day	Year 2000	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of	Death	V V		nty of Death	
	Funeral Director		5. Social Security Number 214–64–2277	6. Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day,	Year) 1956	9. Birthp	place (State or Foreign
- S.	D.		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					1	0d. Inside City Limits
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Baltimore,	permit. Pages Department of Important: If It inny njury or o		4 □ Donation 5 □ Other (Sp	pecify) Gree		Cemetery		2/1/201				Mary.land
Baj	permit. Page Department Important: If any njury or once.		21. Signature of Funeral Service	License	V	2. Name and Addre						
<b>%</b>		4	23a. Part1. Inter the disease, or shock or heart failure. List	complications that caused the deal								Approximate Interval Between
1	Physician		from late Cause (Fin lease or condition resulting in death)	- Nepat	IC	ENCE	PhAI	Lopk	Why	10		Onset and Death
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	po tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to ( * as a consec	quence of):		1		1/-	2.1-		1. 1/2 0.11.0
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09289	# × #	icai		(. Cancomy	cmy	esistan	y en	HWC	erido	nits	7	-weeks
Box 6	h certif ending use as	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,			23d.	Date of delive	,
o.	that the death certifica ed by the attending phi detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of o		Other (specify)					Month	Day Year
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Records,	e ta has	Completed							24a. Was a autop: perfor	sy med?	b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of
Vital	Physician: The this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		-1 3E 804 Oth	or		Check only or			
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			30. Name and address of person	who completed cause of death (fte	m 23a) (Type	Print)	OV	26	1	1000	MOR	roj, leje
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Victoria Elizabeth Wilson NOVEMBER 24 1:05A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GREATER Baltimore Medical BALTIMORE Cente TOWSON Date of Bis... (Month, Day, ) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Set Months Days Hours Min 59 216-52-3042 Director Maryland 1950 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Maryland Anne Arundel Hanover 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? with 1 Funeral items 23a 94 Chesapeake Mobile Court 21076 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within SSA and Mental Hygie is marked other 12th grade Analyst Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1
Department of Health and Merita.
Important: If item 27 is marked any injury or other traumatic even 0 Rione Taylor Mildred Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Walker/Mother 3320 Sumter Avenue Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) King Memorial Park 11/29/10 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Sarvice Lucensee 5240 REisterstown Rd Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician disease or condition Medical resulting in death) Due to (or as a nsequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗌 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 10 Other: 1 🔲 Yes 2/ No Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) na ARL 32. Regist 31. Date filed (Month, Day, Year State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November oberta **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
DEC. 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X MD **Director** 55 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Director BALTIMORE MD 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? ö 212 BETHALST USA 23a ( 21224 Funeral Items : 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 "natural", or 2 **N**o 1 🗌 Yes Specify: BLACK 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than HOMEMALER HUME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ERIC WATKINS pauline holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau ERIC WATKING BALT WE 4716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5112 0 DONNEL 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAGIMURE 21. Signature of Funeral Sepice License CHAVIS, TR or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Enter the disea shock, or heart failure Immediate Cause (Final Acres **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner MoHar if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) burial-t physician Box 68760. Physician/Medical the attending Se 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 □ No Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: Other: 2 No 1 Yes 4  $\square$  Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence မ 6 Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred Certification: After (Month, Day Year) the Hospital or Attending 1 Natural 2 Accident Injury 5 Pending М death. investigation 1 🗌 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f 3 
Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- 000 2010 most -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Lag avan

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 1 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Horth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 317 Curtis Avenue Elkton [ ] Cecil If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 8. Date of Birth
(Month, Day, Year)
June 4, 1930 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday **Funeral** Months 1 🕅 M 2 🗆 F Director 212-28-3121 80 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil E1kton 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 317 Curtis Avenue 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 0 maintenance worker manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Anne Moore Thomas Newman Wyatt any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 Curtis Avenue Elkton, MD 21921 Lola M. Wyatt/souse 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s Department of F 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Director Signature of Eugeral Service Licensee State and Add to Myac Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a cor equence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending iniury work? 1 ☐ Yes 2 ☐ No s after death. Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Records, Division of Vital completed filled in by within 24 hours a To the Funeral I To the Hospital

Box 68760

P.O.

State

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

Registrar DHMH 17 Rev 7/2009 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene-1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Gilbert A. Wilkowski 6:10 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔯 M 2 🗆 F Months Hours Oct 15, Year Maryland 213-60-5387 Director 58 **1**952 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 W. Belvedere Avenue #403 21215 TISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: 3 Widowed 4 X Divorced white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 welder automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Alexander Schultz Stella Niedzielski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estelle Cascio/sister 323 S. Duncan Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If in any injury or o cemetery, crematory or other placel 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 N Qther (Specify) in state Signa Funeral ervice Ronald vice Licensee Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hepatic encephalopathy Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy or Attending Physician; 25. Was case referred to medical examiner?

1 Yes 2 PNo Be completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To 1 Donpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Division To the Hospital or Attend within 24 hours after death To the Funeral Director: A 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🞾 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month. Day, Year) November 15 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Belvedere BAltinure , MD 32. Registrar's Signature State Registrar

Kowski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Novith24, 2010 Virginia White 19:45 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 29 1934 9. Birthplace (State or Foreign **Funeral** Days Min. 228 42 5462 76 Yrs. Director Emporia, Virginia Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2XX No Prince George's Upper Marlboro Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 9811 Stonewood Court 20772 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Yes 2 XXVo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 Divorced Specify: **Black** Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Federal Government Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv. Important: If item 27 is marken any injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lemuel Davis Bessie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred White (Husband) 9811 Stonewood Court, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans Cemetery Dec 9, 2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Rone, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Intertis Immediate Cause (Final varded Physician/ nass.ve disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 N 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Stanley Harten V	•	1- For State	ate of Maryla	and / I		artment of rtificate of			Menta	al Hy		Reg. No.		0	37538	3
Physicia	in/	Registrar  1. Decedent's Name (First, Middl	le,Last)								2. Date of Dea	ath Day	Year	7	3. Time of Death	
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		4a. Facility Name (if not institution 301 Southbound and 2				ľ	46. City, 10 Waldoi		ocation of	Death		1	Charles	Death		
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D 2. Should and Me 7 is ms	٤	19a. Informant's Name/Relations Mae A. Wallace				T .					ral Route Nu				Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	20a. Method of Disposition	(Spouse)		20b. F	Place of Dispos	ition (Name	y Cou	etery,		, Maryla Date		Location - Ci		own, State	$\dashv$
NOFE ages 1 at of H t: If it		1 XX Burial 2 Cremation		rom State	e _ c	crematory or oth	her place)		1	Doo	2 2010	~	1-inton	Mora	·land	
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Ba Pern Dep Imp	H	of thinkeye	m	0/3	91	Fer	ry Roa	d, Cl	inton,	, MD	20735				id Theataid.	
Physician		2 Part I. Enter the disease, or failure. List only one cause		caused th	ne death.	. Do not enter th	ne mode of	dying, su	uch as can	diac or r	respiratory an	rest, sh	lock, or heart		Approximate Intervi Between Onset an	
Examiner	A	Immediate Cause (Final disease or condition resulting in death)												_	Death	-
	1		Due to (or as a	a conseq	uence of	f):										
	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a conseq	uence of	f):										
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executed an and al-transit	Ď		d											$\dashv$		_
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ox 68760, anth certificate be executed attending physician and or use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,		of pregr	_	tal death	3	Ectopic p	pregnan	icy	23	3d. Date of de Month	elivery Da	y Year	
X 68 th cert trendir r use a	icia	past 12 months?	leanura I com	nant at tir	me of de	ath -	her (Speci	fy)								Į
BO) he death the att hed for	Phys	Part II. Other significant condit	known g Unkn		but not re	esulting in the u	indorlying (	causo aiv	en in Part	+ 1	23e Did	tobacco	use contribu	ute to th	e cause of death?	_
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ds, equire een sig	eted	<u></u>					_				24a. Was				psy findings availab	
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Re It Le	ပ္ပို	25. Was case referred to medica	31				21	3.Place c	of Death (C	Check or		21	40   1	7 165	2 No	=
Vita ysician direct	8	examiner? 1 ✓ Yes 2 No	(Hospital:	Inpatient	t 2	ER/Outpatient					Home 5	Resid	dence 6	Other:	Scene	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be writhin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring		27. Manner of Death	28a. Date	e of Injury th, Day Yea , 2010	/ ar)	28b. Time of I	njury 28		at Work?		28d. Describe Oriver auto			j		
ivision I or Attendi after death. Director:	Certification	1 Natural 5 Pend 2 Accident Inve	stigation			2002 hrs		4-7	es 2 🗸 N	No			5			
Divis al or A after Direction	ij	dete	ld not be			ome, farm, stree		office bui	ilding, etc.		or Town,	State)			al Route Number, Cit way, Waldorf, MD	
Division To the Hospital or Attending 24 hours after death To the Funeral Director:		4 Homicide	hysician: To the be		-	d / Highway		ime, date	e and plac					<u> </u>		T
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Exa	aminer:On the basis	of exami	ination a	ind/or investigat	tion, in my	opinion, d	death occi	urred at	the time, date	and pl	lace, and due	to the	cause(s)	
F & F 8	Me	29b. Signature and title of certifie						License					. Date signed			
		Margarite !	The Thel	1				O.C.M	I.E.			No	vember 2	7, 201	10	
811	İ	30. Name and address of person	Assistant Me				enn Stre	et Bai	ltimore	MD 2	1201					
	_	Margarita Korell MD.  31. Date filed (Month, Day, Year)		Registrar's			enn oue	ict, bai	itilliore,	1010 2	1201				_	$\dashv$
		DEC 0 1 2010	house	Ø. ×	par	Car										

	1- For State of Marylan	nd / Department of Health and M Certificate of Death	lental Hygiene
Physician			2. Date of Death Month Day Year  10020 0 M
/Medica Examine		4b. City, Town, or Location of Death	4c. County of Death BUHMORE
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 1 M MXF 85	last birthday    If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year) 12/17/1924 9. Birthplace (State or Foreign Country) North Carolina
the Maryland 28a-f show		y, Town or Location	10d. inside City Limits 1
with the Mar a or 28a-f sl	Maryland Baltimore Mic	dle River	10g. Citizen of What Country?
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be rediffed at once.	3 X Widowed 4 □ Divorced If Yes, Give X Year or Dates:	S. 21220 S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	U. S. A.  poify Yes or No- Rican, etc.)  14. Race · American Indian, Black, White, etc.  Specify:  White
faryland 21215-003 2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", "aumatic event, the Medical Exer- To Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)	16b. Kind of Business/Industry
yland 2 yland 2 would be filed v whental High arked other attic event, th	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
re, Maryle 1 and 2 should Health and Mer Health and Mer Health and Mer To	19a. Informant's Name/Relationship (Type. Print)  John Wright, Jr. (Son)	Kinnie 19b. Mailing Address (Street and Number or Rura 109 Huston Court Hunt	Horner  I Route Number, City or Town, State, Zip Code)  SVIlle, AL 35806
Baltimore, Maryland 21215-0036  Permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or myoritant: If item 27 is marked other than "natural", or myoritant: If item 27 is marked other than "natural", or myoritant if item 27 is marked other than "natural", or marked by E. Completed by E. Completed by E.	20a. Method of Disposition  1  ■ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  Ala	lace of Disposition (Name of Demetery, crematory or other place)	ate 20c. Location - City or Town, State  /29 Burlington, NC
Baltii permit. Departm Importan any inju	21. Signature of Funeral Service Licensee  23. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	22. Name and Address of Facility  Bruzdzinski Funeral  1407 Old Eastern Av  n. Do not enter the mode of dying, such as cardiac o	Home PA
68760, Fifticate be executed with the principle of physician and as the burial-transit edical Examiner	d	Libred uence or):	Onset and Death
ecords, P.O. Box 6i law requires that the death certific as been signed by the attending p 2 should be detached for use as it pleted by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown  1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of december of the past 12 months?	death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
cords, P.O.  w requires that the de been signed by the should be detached	rait ii. Other significant conditions contributing to death but not resu	ilting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, I or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be derification: To Be Completed by	25. Was case referred to medical		24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No 1 □ Yes 2 □ No
of Vita Physician: this certifical director, prize Be C	examiner?	26. Place of Death  ER/Outpatient 3 □ DOA Other: 4 □ Nursing Horn	(Check only one)  ne 5 ☐ Residence 6 ☐ Other (Specify)
Division of Vital Reform to the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	27. Mayher of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	001 7	8d. Describe how injury occurred
Divis pital or Att urs after d and Direct lilled in by I		, , , , , , , , , , , , , , , , , , , ,	8f. Location (Street and Number or Rural Route Number, City or Town, State)
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in I	29a. Certifier  (Check only one)  1 ▼ Certifying Physician: To the best of my know and manner: On the basis of examinat and manner stated.		and due to the cause(s) and manner as stated.  Indicate the time, date and place, and due to the cause(s)
• i	29b. Signature and title of certifier  Pay  Pay	29c. License number RES 0000	29d. Date signed (Month, Day, Year)
Q	30. Name and address of person who completed cause of death (Item DR , KOUSALY & ARUDAGIR 1, 9000	23a) (Type, Print) FRANKIM SQUARE DRIVE, BO	i.Himoke,MD 21237
State Registrar	31. Date filed (Month, Day, Year)  DEC 0 1 2010  Across 4	FRANKIM Square DRIVE BO	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Husick Winter Month 2010  $A^{M}$ November 2:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 8926 Cowenton Avenue Perry Hall Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Days Director 185 24 3464 79 Nov. 1, 1931 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ampling or other traumatic event, the Medical Examiner must be norified. \*\* once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore Maryland Perry Hall 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8926 Cowenton Avenue 21128 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Automotive Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Husick Helen Preplett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Stiffler (Husband) 8926 Cowenton Avenue Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens 12/2/2010 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Colon Immediate Cause (Final Letast Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death Month Year been signed by the a should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform death? certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2X No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural work? 5 Pending s after death. I Director: Aft 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 11/30/2010 5 Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 6565N. Charles St.

DHMH 17 Rev 7/2009

State Registrar

FUSTER, MY

31. Date filed (Month, Day, Year) **DEC 0 1 2010** 

32. Registrar Signatu

TOUSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G910 12/09/10 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Willed Physician/ MAYCAMP NOON 2 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DARK PASAdeNA 2003 A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 😾 F Months Days Month Day **8**6 16 0784 87 Director 216 Texas Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2003 Park Drive 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 10 Administrator Coppers Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Camp Lillian Sparks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19971 Jane Fuller - daughter 120 Glade Circle West Rehoboth Bch, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of N 1 Burial 2 X Cremation 3 Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11/23/10 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one causterioselerotie Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is listed as enter the cause). Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a
To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practioner: To the basis of my anomalogo death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State Registrar

DHMH 17 Rev 7/2009

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		State		epartment of Health Ce <i>rtificate of Death</i>	, ,	0010 07510
		Registrar  1. Decedent's Name (First, Middle, Last)		Sertificate of Death	2. Date of Deat	h 3. Time of Death
Physicia Medi		CYN	THIA GROS	S WIELAND	1 <sup>Month</sup>	21 2010 9:39 AM
Examir	ner	4a. Facility Name (if not institution, give street and nur	mber)	4b. City, Town, or Location		4c. County of Death
Funeral		675 Willowby Run  5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Pasadena	er 24 Hrs. 8. Date of Birth	Anne Arundel  9. Birthplace (State or Foreign
Director		217 58 0883   1 M 2 X F	60 Y	Months Days Hours	Min. (Month Day,	1950 Country) MD
ind show at	5	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town of	or Location		10d. Inside City Limits
Maryla 28a-f s etified	Director	MD Anne Arundel	Pasade	ena		1 ☐ Yes 2 ☑ No
h the	a Di	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Country?
ms 2: must	Funeral I	675 Willowby Run		211		U.S.A.
ING 21215-0036  s filed within 72 hours after death with the Maryland tal Hyglene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y F	Armed Fo	edent Ever in U.S. prces? 2 XI No	<ol> <li>Was Decedent of Hispanic O If Yes, specify Cuban, Mexica</li> </ol>	rigin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036 within 72 hours after glene. er than "natural", o , the Medical Exam	Completed by	3 Widowed 4X Divorced If Yes, Giv	/e	1 ☐ Yes 2 ☐ No Specify	y:	Specify: White
15-(	nple	15. Decedent's Education (Specify only highest grade completed	) (0	ecedent's Usual Occupation Give kind of work done during mo	st of working	16b. Kind of Business Industry
212 vithin giene. er thau the N		Elementary/Seconday (0-12) College (1	- <del>4</del> 01 3+)	fe. DO NOT use retired) School Teache	r	St. Jane Frances School
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Maryl 2 should I th and Me 27 is marl traumati		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and Numb		
Jre, Marylal  Tand 2 should be of Health and Ment fitem 27 is marker other traumatic e		Corinne Wieland - da 20a. Method of Disposition	20b. Place of D	575 Willowby isposition (Name of		ena, MD 21122  20c. Location - City or Town, State
Page Page ant: If		1 $X$ Burial 2 $\square$ Cremation 3 $\square$ Removal from 4 $\square$ Donation 5 $\square$ Other (Specify)	State Glen H	crematory or other place)  laven Mem Pk		Glen Burnie, MD
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licensee	, , , ,	22. Name and Address of Facil	ity GJ Gonce	Funeral Home, PA
		23a. Part 1. Enter the disease, or complications that of		109 KIVIera	Drive Pas	adena, MD 21122
Physician/		snock, or neart failure. List only one cause on ea Immediate Cause (Final	ch line.	CANCER	s cardiac or respiratory arres	Approximate Interval Between Onset and Death
Medical		disease or condition resulting in death)  a. Due to	or as a consequence of):	CHOLEK		Short and Boatin
Examiner	<u>.</u>	Sequentially list conditions, b.				
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the de by the	hysi	1   Yes 2   No 4   Pregi 9   Unknown 9   Unkn		5 □ Other (specify)		Month Day real
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vito nysicie nis ceri direct	To Be	examiner? 1  Yes 2 No Hospital: 1	Inpatient 2 ER/Outpa	Other	th (Check only one) ursing Home 5 Residen	ce 6 Other (Specific)
ing Pt		27. Manner of Death 1 X Natural 5 □ Pending (Mont	of injury 28b. Time h, Day, Year) injur	of 28c. Injury at	28d. Describe how	
Attend death ctor: /	Certificate	2 Accident Investigation 3 Suicide 6 Could not be	of Injuny At home form	M 1 ☐ Yes 2 ☐		
al or A safter Il Dire		4 ☐ Homicide determined 28e. Place buildir	of Injury - At home, farm, g, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the be	est of my knowledge, dea	th occured at the time, date and	place, and due to the cause	o(s) and manner as stated. place, and due to the cause(s) and manner stated.
o the lithin 2 the Formplet	_	only one) 3 Certifying Nurse Practioner: T 29b. Signature and title of certifier	o the best of my knowledg	e, death occurred at the time, date	and place, and due to the ca	ause(s) and manner as stated.
F≯Ĕŏ		Marlenzen 1	40	29c. License number		d. Date signed (Month, Day, Year)
				75757 e, Print)		11/22/2010
		30. Name and address of person who completed cause MARK KIM, MY 1412  31. Date filed (Month Person Pear) 1 2010 32. 55	N. CRAIN	HWY 6B 618	NBUILNIE	MD 2106/
State Registra	e r	32. F	gistrar's Signature	parker		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 2010 10:00P.M1 Lloyd Leroy Anderson 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Reeders Memorial Home Washington Boonsboro Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
June 12,1928 7. Age (In vrs. last birthday 1 M 2 □ F 216-22-8640 82 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 18438 Woodside Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 \( \subseteq No \) Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 M Married If Yes, Give Year or Dates: 1 □Yes 2X No 1949 Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 n Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William McKinley Anderson Lillian Minerva Heefner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Anderson (Wife) 18438 Woodside Drive Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov.15, 2010 Williamsport, MD Greenlawn M.P. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ROBABLE MUDGARDIAL MEAKETON 5-7 mm Due to (or as a consequence of): SEVERUS CORENANT MUTHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): KOHAL STAGE END Due to (or as a consequence of): OBSTRUCTURE LUNG DISCORSE CHRONIC SMAG tAns. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ∐Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗆 Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) NOU 12, 2010

301-432-8470

**Physician** /Medical Examiner and requires that the death certificate be

**Physician** 

/Medical

Examiner

Director

\$

Completed

Be

10a. State

**Funeral** 

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the headen

permit. Pages 1 and 2 should be filed within De artment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Medical Ones.

RME: ANDERSoN LL04几 Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

Examiner the attending physician Physician/Medical detached signed by t d be detach by page 2 should Completed has certificate Certification: To After 1

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu +3 5H2+1 State

Hospital or Attending Physician: The law

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 DR. GHAZALA OADIR, 31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifie

NOV 15



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Medical

17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Annette Boyce November 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 14624 Country Creek Lane North Potomac 8. Date of Birth (Month, Day, Year) Feb 6 1916 if Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F Months Pennsylvania 163-07-8865 94 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 20878 14624 Country Creek Lane United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. o, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Waitress Restaurant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of the stand of the standard o မ Nellie O'Rourke permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is markel any injury or other traumatic once. Joseph Boyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14624 Country Creek Lane, North Potomac, MD 20878 Annette Burns/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State cemetery, crematory or other place, Unknown Philadelphia, PA Unknown 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Devol Funeral Home intes E. L.D 10 E. Deer Park Drive, Gaithersburg MD 20877 MO1116 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 2 💢 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page performed? Yes 2X No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 Tes |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar DHMH 17 Rev 7/2009

State

To the within 2 To the I

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

NOV 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Shishir Kumar Khetan, M.D. 1201 Seven Locks Road, #111, Rockville MD 20850

D 61630

29d. Date signed (Month, Day, Year)

November 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Mary Lou Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M M XX Months Days Hours Min. 8/317 1916 172-03-5143 PA **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10h County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 Yes XX No Anne Arundel Odenton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21113 USA 1319 Farrara DR. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceus Armed Forces? permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 11. Marital Status 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify: White ¾X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bakery Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louanna Patch Edward Hargreaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 Farrara DR. Odenton, MD 21113 Daughter Carol Lyn Brown 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11/10/2010 Johnstown, PA Richland Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Suneral Service Licenses als 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the see ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNOSERSIS Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death 9 Unknown the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: Certificate: To 1 🗆 Yes Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Manne of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) injury work? Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 only one Signature Name and address of person who completed pause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 09 2010 Registrar

0510001/8/11 Burkhardt, Virginia Baltimore. Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	State of Maryland / Department of Health and Mental Hygiene												
		State Registrar			Ce	rtificate of L	Death		ı	Reg. No. U	IU	3/34/	
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Medic	al	4- F- 22 N Cf 4 1 42 A	Virginia		rknaro			( D!)	Novemb		2010		
Examin	er		Adventis	+ Hosp		4b. City, Town, or	will.	e		l M	on to	jonery	
Funeral Director		5. Social Security Number 190-30-4733	6. Sex 1 ☐ M 2 ■ F	7. Age (In yrs. 18	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jan. 18	, Year) , 1941	Co	rthplace (State or Foreign ountry) nnsylvania	
ld now	١	Usual Residence of Decedent  10a, State 10b, County		10c. City	v. Town or Lo	ocation						10d. Inside City Limits	
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with s 23a ust b	Funeral	3455 Kemptown C	hurch Road	l		2177	70			U	.S.A.		
death items		11. Marital Status	12. Was Deced	ent Ever in U.S		Was Decedent of Hi If Yes, specify Cuba	spanic Orig	in? (Spec	cify Yes or No- Rican, etc.)		ace - Ame	erican Indian,	
s after al", or Examir	d by	1 ☐ Never Married 2 ☐ Marr 3 ■ Widowed 4 ☐ Divorced	ried 1  Yes If Yes, Give Year or Dat	2 🎩 No		1 ☐ Yes 2 ■ No			, ,	Spec		White	
hours natur	plete		nt's Education st grade completed)	-	16a. Dece	edent's Usual Occupa kind of work done d	ation	of workin	ng l	16b. Kind of	Business		
vithin 72 piene. or than the Me	Completed	Elementary/Seconday (0-12)	College (1-4	1 or 5+)	life. L	NOT use retired) Homemake		or working	9	O	wn Ho	ome	
filed v al Hyg d othe		17. Father's Name (First, Middle, Li	ast)				18. Mother	r's Name	(First, Middle, I	Maiden Surna	me)		
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shou hand 7 is m traum		19a. Informant's Name/Relationsh				ing Address (Street a				-			
and 2 Health		Duane W. Burkha 20a. Method of Disposition	rdt, Son	20h P	<u> </u>	O Welsh Ro	oad, (		nersburg	g, MD . 20c. Locatio			
Page 1 nent of int: If it		1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State C	emetery, cre Res	matory or other place thaven I Gardens	e) No	_			•	Maryland	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In unaturally, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Faneral Service L	Ansee	100	2	2. Name and Addres	s of Eacility	Liams	s, P.A.	, Fune:	ral H	lome	
		23a. Part 1. Enter the disease, or	complications that ca	used the death		26401 Rids ter the mode of dying					Land	Approximate	
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Medical Examiner		resulting in death)	Due to (o	r as a consequ			<u>U 17-U</u>	,, 0, (,	S/K				
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	_	23b. Was decedent pregnant in the past 12 months?  1 Yes 27 No 9 Unknown		irth 2 🗌 Feta ant at time of d	Ideath 3	Control of the contro	у				Date of de Month	livery Day Year	
that the	by Ph	Part II. Other significant condition	ns contributing to dea	ath but not resi	ulting in the	underlying cause giv	en in Part I.		23e. Did to	bacco use co	ntribute to	the cause of death?	
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To the Within Com		29b. Signature and title of certifier			2	29c. License	585	0/	+	29d. Date sign	05	5-10	
<b>7</b> _	4	30 Hame and address of person w	- 1	of death (Item	23a) (Type,	Print)	١ /			0 - 1	51/	MD 20150	
12			wari M	D 1011	O MO	recular	Dr 3	mre	- 206	Kodev	1110	MU 20150	
Stat	е	31. Date filed (Month, Day, Year)	32. Reg	gist ar's Signat	ure	1.11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $^{\text{Day}}6$ ,  $2\overset{\text{Year}}{0}\overset{\text{Day}}{1}$ November Physician/ 8:45a Betty Lou Blau Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. 12615 West Oak Drive Airy 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number Funeral (Month, Day, Year July 17, I 1 □ M 2🏝 F Months Davs Hours Min Virginia 63 Ĩ947 Director 219-48-3923 Usual Residence of Decedent Show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 3a or 28a-f sh t be notified a 1 Tyes 2 K No Maryland | Frederick Mt. Airv 10f Zip Code 10g, Citizen of What Country? 23a Funeral "natural", or items 23 21771 United States 12615 West Oak Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates ar than "he." he Medical F 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Office Manager Electronics 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item Z7 is marked c any linjuy or other traumatic eve once. and Mental ည James Franklin Fellers Florence Virginia Fincham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven K. Blau/ Husband West Oak Drive, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 11/10/10 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Home P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or se a consequence of) if any, reading to immediate cause. Enter Underlying and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE nse : 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year Month Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page performed? Yes 2 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify) this ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death.

e Funeral Director: Afte pleted filled in by the fur 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🕢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 200 November 9, 2010 D45014

State Registrar

DHMH 17 Rev 7/2009

18111 Prince Philip Drive, Olney, Maryland # 204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Roma

Isabella C. Martire, M.D.

31. Date filed (Month, Day, Year)

			Please							Are Legible	е.
			For State	State of M	arylan	•	artment of F		Mental Hyg	iene 10	37549
			Registrar  1. Decedent's Name (First, Middle, Las	+)		Cer	tificate of E	<i>Jeain</i>	2. Date of Deat	leg. No.	
П	Physicia								_ Month _	Day Year	3. Time of Death 9:30 P M
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-	LAGIIII	CI	13217 Briarcliff	Dr.			Hagerst			1	on County
	Funeral		Social Security Number     6. Security Number	9x 7. Ag		st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. E	Birthplace (State or Foreign
	Director		081-40-5322 Losual Residence of Decedent	- W - Z - AL   (	55	Yrs.			Sep. 9,	1945   Ne	ew York
	and show	ō	10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryl 28a-f otifiec	irect	Maryland Washington	on County	Hag	erstow	m				1 ☐ Yes 2X No
	h the	al D	10e. Street and Number	•			10f. Zip Code		1	10g. Citizen of What (	Country?
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(0	er dea or ite niner	y Fu	11. Marital Status  1  Never Married 2  Married	Armed Forces?	No.	. 13. Y	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, Wh	· ·
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by Funeral Director	3 Widowed 4 XDivorced	If Yes, Give Year or Dates.		1	☐ Yes 2 X No	Specify:		Specify:	White
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/lar	d be f Menta arked atic ev	유	Julian Archer					Janet W	illiams <i>a</i>	Archer	
Maryland	should be and Ment is marker raumatic e		19a. Informant's Name/Relationship (Ty				9			City or Town, State, 2	
	and 2 Health em 27 ther tr		Mark A. Badger-son	n	Took Di		nchester	Terrace		ter, MA 01	
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Box 68760	eath certificate be attending physic I for use as the b	ciar	23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	У		23d. Date of d Month	Day Year
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Ä	sician: The la certificate ha irector, page 2		25. Was case referred to medical				26 Pla	ice of Death (Che	1 \( \text{Yes} \) 2		es 2 🗆 No
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Division of Vital Records,	or At after c Direct in by	Certificate:	4 Homicide determined	28e. Place of Inju building, etc	iry - At hon :. (Spec <i>ify)</i>	ne, farm, stre	et, factory, office		28f. Location (Str City or Town,	eet and Number or R , State)	u <i>ral R</i> oute Number,
Ω	Hospital or Attending Physician: The law requires that the death certificate to 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicated filled in by the funeral director, page 2 should be detached for use as the I		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowle	edge, death o	ccured at the time,	date and place, a	and due to the caus	e(s) and manner as s	tated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 Medical Examir only one) 3 Certifying Nurs	<b>ner:</b> On the b <b>a</b> sis of ea	kamination	and/or investi	gation, in my opinio	n, death occurred.	at the time, date and	d place, and due to the	e cause(s) and manner stated.
_	To the with To the company of the co		29b. Signature and title of certifier	. (/.	1		29c. License	number	29	9d. Date signed (Mon	th, Day, Year)
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2	4-8		30. Name and address of person who co	1/ / -	eath (Item :		rint)	سال به	of Cana	and Oak	1 to near town
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			State of Marylar	nd / Depa	artment of H	lealth and	Mental Hyg	iene	07750
			1 - State Registrar	eg. NoZUL	3/550				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Death     Month		3. Time of Death
	Medic		Virginia Louise		Brake		November	8, 2010	8:10 A <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		ath	4c. County of Dea	
			Homewood at Williamsport	In mile the land to miles of	Williams If Under 1 Year		- 10 D. 1. (B):11	Washing	
	Funeral Director		5. Social Security Number  213-18-9829  6. Sex 1	Yrs.	Months Days	Hours Mir	n. (Month, Day,	Year) Co	rthplace (State or Foreign
			Usual Residence of Decedent				Jan. /,	1922   Ma	ryland
	and show	5	10a. State 10b. County 10c. Ci	ty, Town or Loc	cation				10d. Inside City Limits
	//anyl //8a-f tifiec	Director	MD Washington W	illiams	sport				1 ☐ Yes 2🏋 No
	the l	Ö	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	ountry?
	s 23a	era	16505 Virginia Ave. 322B		21795			U.S.A.	
	death item ier m	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	
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<u>la</u> u	l be fi fenta rked tic ev	욘	John Henry Martin			Ruth V	Vertie Gea	arhart	
ary	hould and N is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street a	nd Number or R	Tural Route Number,	City or Town, State, Z	ip Code)
Σ	od 2 sealth an 27 i		Sylvia R. Brake/Daughter	217 0	ak Forest	t Ave.,	Catonsvil	lle, MD 2	1228
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items Z3a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. 1   Burial 2 □ Cremation 3 □ Removal from State	Place of Dispos	sition (Name of natory or other place	e)	Date	20c. Location - City o	r Town, State
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			23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.	h. Do not ente	r the mode of dying	, such as cardia	ac or respiratory arres	st,	Approximate Interval Between
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89	ath certifica attending p for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna		1			23d. Date of de	elivery
Вох	eath e	icia	in the past 12 months?  1 ☐ Live Birth 2 ☐ Fet 1 ☐ Ves 2 No 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	/		Month	Day Year
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⋝	Physic this ce al dire	၉	1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐	4	t 3 DOA Other	4 Nursing	Home 5 Resider	nce 6X Other (Spec	SSISTED
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:	io the Hospital or vithin 24 hours after To the Funeral Direction of th	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	n and/or investi	igation, in my opinior	n, death occurred	d at the time, date and	I place, and due to the	cause(s) and manner stated.
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	OF.		ATTENE MD		DL	1429	0 1	Yovembar	15,2010
	ZT		30. Name and address of person who completed cause of death (Iten	1 23a) (Type, P	rint)	, ,	Walta	Read Ar	my mas ctr
	2		Timothy L. Krohe MD Gen	il Inde	and Mad.	Clinic		ortan OC	- 120307
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	Registra	r	COTO CARCONE	A. All					

			1 - For State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygid	ene	
			Registrar  1. Decedent's Name (First, Middle, Last)	Timcate of Death	2. Date of Death	g. No. /	<del>-3755</del> 1
	Physicia		ESSIE MORRIS BROWN		Month Nov.	5 2010	3. Time of Death 5:20p M
	Medi Examii		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	110 7 .	4c. County of Death	7.20p
900			Collington Episcopal Life Care	Mitchellville		Prince Ge	orges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	0 Dieth	Slage /Ctate + + Fi
	Director		467-30-3104 1 □ M 2 M F 87 Yrs.  Usual Residence of Decedent	Wionting Bays Flours Willi.	Oct. 13,	1923	TX
	at at	5	10a. State 10b. County 10c. City, Town or L	ocation			0d. Inside City Limits
	flaryla Ba-f s tiffied	ect	MD Prince Georges Bowie			T	1 ☐ Yes 2X No
	the N	₫	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	ntry?
	s 23s nust k	Funeral Director	16401 Ellesberry Ct.	20716		USA	,
	death item ner n		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Americ	
36	after I", or kamil	ğ	1 Never Married 2 X Married 1 Tyes 2 No	1 ☐ Yes 2 ☒ No Specify:	nican, etc.)	Black, White,	etc.
8	ours atura cal E	ete	3 Widowed 4 Divorced Year or Dates.  15. Decedent's Education 16a Dece				ack
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yla	should be file and Mental I 7 is marked o raumatic eve	욘	Jesse James Hutchins	Bessie L	ee Hutchi	ins	
Nar	shou raum			ng Address (Street and Number or Rura	l Route Number, Cit	ty or Town, State, Zip C	Code)
e,	and 2 Health em 27 ther tr				Bowie, MI	D. 20716	
Baltimore, Maryland 21215-0036	age 1 and 2 should be file ont of Health and Mental I tt If item 27 is marked o y or other traumatic eve	u	1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State	matory or other place)	Date 20	c. Location - City or To	wn, State
Iţi	nit. Pa artme ortan injury		4 Donation 5 Other (Specify)  Lakemont  21. Signature of Pungral/Service Licensee			VIDSONVILL	
Ba	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1		MINITED A HISTORY M	2. Name and Address of Facility arshall-March Fune	ral Home	of Marylar	ıd
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent	308 Suitland Rd.  er the mode of dying, such as cardiac or	r respiratory arrest.	MD 20/46	Approximate
(N) W	Ph sician/		Immediate Cause (Final	, 5	, ,		Interval Between Onset and Death
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	Examiner	L	Sequentially list conditions, b. Stare Four Right 1	lip Ulcer		4	
	p #	nine	if any, leading to immediate Due to (or as a consequence of):			- 3	
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760	eath certificate be executed attending physician and for use as the burial-transit	ledic	d. Aleriai Tibriliadi			_	
Records, P.O. Box 687	certif inding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	
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uc	ath. rr Afte re fun	icat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work?  M 1  Yes 2  No	bd. Describe now in	ijury occurred	
ISI.	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 2		and Number or Rural F	Route Number,
á	italo ursafi ral Di lled in				City or Town, Sta	•	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier (Check (Check Check C	igation in my opinion, death occurred at t	ha time data and pla	and and due to the sour	(-)
	ithin 2	≥ ].	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, of 29b. Signature and title of certifier	eath occurred at the time, date and place.	and due to the caus	se(s) and manner as stat	ed.
	F ≥ ¥ ĕ		Pabila L M.D.	29c. License number	29d.	Date signed (Month, Da	ay, Year)
	/	-	30. Name and address of person who completed cause of death (Item 23a) (Type, P	D66658		111012	- 5 . 0
/	all.			Rd. #306 Lanham,	MD. 207	06	
	Stat	~ 1	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registra	r	NOV 1 2 2010 Sener D. Barks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy Roslyn Bozman 08 2010 Physician/ Month 3:15p <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pocomoke Worcester Hartley Hall Nursing Home Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day Year) 1920 Days Country) 1 M 2 N Months Hours Min. Director 90 218-20-7123 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Md. Somerset Dames Quarter 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24892 Deal Island, Road 21821 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify: Completed 3 ₩idowed 4 ☐ Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Fashion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry lee Bozman Gladys Webster other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is Kenneth Bozman 30894 Cedar Dr., Princess Anne, MD. 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Beechwood Cemetery 11-11-2010 Princess Anne, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, 21853 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only one cause on each line Imrediate Cause (Final DEMENTIA Physician/ ALZHEIMER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) Exami Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 N 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \sum Yes 2 \sum No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one) 29b. Signature and title of certifier 00062172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

Sharad R 31. Date filed (Month, Day, Year) 1604 MARKET

ST.

SATYAL, MD

32. Registrar's Signature

POCOMOKE CITY

MI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lois Jane Brookhart 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Virginia 1 □ M 2 😿 F Months Hours Min (Month, Day, Yea 83 219-22-1148 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.
The marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State Director Anne Arundel Severna Park MD 1 🗌 Yes 2🏋 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21146 USA 311 Fernwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 X No Specify: Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ည Angelo Kary Nina Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1164 Charing Cross Drive Crofton, MD 21114 Patricia Heathcote/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of F
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) November Metro Crematory, INC. Baltimore, MD 2010 Signature of Funeral Sovvice Licensee Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of): Exami The law requires that the death certificate be executed tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autops certificate 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes ပ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28c. Injury at work? 1 ☐ Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a Certifier 🕽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number and address of person who completed cays of death (Item 23a) (Type

State Registrar Date filed (Month, Day, Year

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		1. Decedent's Name (First, Middle, L							2. Date of D	Death	Day Year	3. Time of	Death
Physician/ Medical	L	Arlin Eric Buk							Novem	ber	8 201	0   12:35	A M
Examiner	ı	a. Facility Name (if not institution, g	del Ger	AAMC	230	F	FNI	Location of Deat	113		c. County of De	4	
Funeral Director		159-24-3504	. Sex 7. Ag	ge (In yrs. Ia 87	ast birthday) Yrs.	Month	ler 1 Year s Days	If Under 24 Hrs Hours Min.		Birth Da <i>y, Year)</i> 16,	1923	irthplace (State o iountry) Pennsylv	r Foreign rania
rylandf show ied at		Joan Residence of Decedent  10a. State  Maryland  10b. County  Anne	Arundel	10c. Cit	y, Town or Lo	cation	Anna	apolis		-		10d. Inside Cit	ty Limits
leath with the Maryland items 23a or 28a-f shoer must be notified at Frunst be notified at Funeral Director		   Oe. Street and Number   1854 Burley Roa	ad			10f. 2	Zip Code	21409		10g. C	Ditizen of What G	Country?	-7-110
ath wi	<u> </u>	1. Marital Status	12. Was Decedent	Ever in U.S	3. 13.	Was Dec	edent of Hi	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No	)- )-		nerican Indian,	
° L.9 \	5	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  d 1 🔀 Yes 2 🗆  If Yes, Give  Year or Dates.		TT			n, Mexican, Puer Specify:	to Rican, etc.)		Black, Wh		
5-0 2 hour "natur adical		15. Decedent's (Specify only highest			16a. Dece	kind of w	ork done c	ation during most of wo	rking	16b.	Kind of Busines	s Industry	
21215-003 given 72 hours a given from "natural", the Medical Ex. Completed		Elementary/Seconday (0-12)	College (1-4 or 5+	5+)	life. D		se retired) [esso]	<u> </u>			Educa	tion	
Maryland 21215-0036 2 should a filed within 72 hours after thith and Mental Hygiens 27 is marred other than "natural", or traumati event, the Medical Exam To Be Completed by		7. Father's Name (First, Middle, Las Percy Emmanuel						18. Mother's Na	me (First, Middl an Viol				
Mary		19a. Informant's Name/Relationship Ellen Laurent/		****				and Number or Ri olestone				Zip Code) ne, FL 3	2092
Baltimore, bernit. Page 1 and bepartment of Hea mportant: If item any injury or other	2	20a, Method of Disposition 1 ☐ Burial 2 XXCremation 3	☐ Removal from State	,   0	lace of Dispo emetery, crea	matory or	other plac		Date	1	Location - City		
Iltim	-	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Ba								, Maryla ral Home	
Bal permii Depar Impor any ir	1	Myslin T.	Woler							_		s, MD 21	
- Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	omplications that cause y one cause on each lin	e.				g, such as cardia Lear t		_	ase	Approximate Interval Betwoen Onset and I	ween
Medical Examiner		resulting in death)	a. Due to (or as										
ner mere		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or es	a consequ	sandi cry								
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exam	2	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	I death 3	Ectopie Other	c pregnanc (specify)	у		[g]	23d, Date of o	,	<b>⁄e</b> ar
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nding Path.: After a funer.	1	1 Natural 5 Pending 2 Accident Investigat	(Month, Da	iy, Year)	injury	M	28c. Injury work 1 $\square$		28d. Describe	how inju	iry occurred		
Division of Vital Records, tal or Attending Physician: The law requires is after death.  Staffer death.  Subjector After this certificate has been signed in by the funeral director, page 2 should be a for the funeral director.		3 Suicide 6 Could no 4 Homicide determine	t be			eet, facto	ory, office		28f. Location City or To			ural Route Numb	er,
De Hospital in 24 hours ne Funeral pleted filled		(Check 2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	amlaatiaa	and/ar inues	Almohine 1	n mu aninia	a death againmad	at the time date	and alan	a and due to th	agueo(e) and mar	nner stated.
To the within To the Comp		29b. Signature and title of certifier	00	De	Put	7 25	9c, License	number OLO5	4	29d. D	ate signed (Mor	th Day, Year)	
\$8710	3	30. Name and address of person wh	o completed cause of c	leath (Item	23a) (Type, F	Print)	69	5 A	mer	ies	+ 2	1035	
State Registrar	3	11. Date filed (Month, Day, Year) NOV 10	2010 32. Régistr	ar's Signat	B. A	bare	~						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37555 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Collins Onata Elaine 1210PM renter 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital 7. Age (In yrs. last birthdav) . Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min May 24, 1931 Count Michigan 1 □ M 2 🔯 385-28-9542 79 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d Inside City Limits 10a State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 USA 16601 Buford Drive items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Library Librarian permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, to and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Marie Culverwell Otto Eugene Gegenfurtner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21795 William P. Collins-Husband 16601 Buford Drive Williamsport, Maryland Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Hagerstown Crematory Nov.15,2010 Hagerstown, Maryland 21, Signature of Puneral Service Licer Osborne Aftererally Home, P.A. MD 21795 Conococheaque St. Williamsport, P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bety Jee Doge Hay Immediate Cause (Final AZCINOMY Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-t Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) Pregnant at time of death 9 Unknown the detached 9 Unknown P.O. s been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner's Hospital Other: 1 🔲 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 Natural 5 Pending injury ours after death.

neral Director: Af
filled in by the fu 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours at To the Funeral D completed filled in Hospital Medical 29a, Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titl License number 29d. Date signed (Month, Day, Year) who of death (Item 23a) (Type, Print) USH 3 istrar's Signatur Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 Physician/ 4:10 am 2010 Yoon Soon Chung November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Randolph Hills Nursing Home Wheaton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral (Month, Day, Year) 14 1 🗆 M 2 🕱 F Months Days Hours Min 95 Korea 217-94-5068 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State aţ 10c. City, Town or Location within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 X No Maryland Silver Spring Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20902 U.S.A. 11420 Heathercrest Lane or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black White etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. "natural", Asian 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ukn Choon Yim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Terry Chung - Son MD 20902 11420 Heathercrest Lane, Silver Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/16/2010 Silver Spring. 4 Donation 5 Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee Kowe 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death
Many Year Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Stroke 1993 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No ō Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown g 🗌 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an death? 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After a completed filled in by the funera 1 X Natural 5 Pending 2 No 1 Ves Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Lee.

NOA 4

Byong K.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itom 23a) (Type, Print)

M.D.

D21033

13000 Georgia Avenue, Silver Spring, Maryland 20906

29d. Date signed (Month, Day, Year,

November 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $1:55p_{M}$ Cleveland Cox <sup>D</sup>31, 2010 Physician/ October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges **Examiner** Dateleaf Heights Avenue 510 Capitol 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 66 Vrs 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) Apr. 6, 1944 1 🕱 M 2 🗆 F Days west? Virginia 233-70-9667 **Director** Apr. Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Capitol Heights Prince Georges M D 1 🏲 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 Funeral Dateleaf Avenue United States 510 12. Was Decedent Ever in U.S. 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1968 1 ☐ Yes 2 No Specify. American 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry
D.C. Government 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Seconday (0-12) Protective Service Police Department Elementary/Se 12th Officer (Lieutenant) Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Brown Cox Charlie Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 510 Dateleaf Avenue, Capitol Heights, Maryland wife Deloris Ann Cox permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Brentwood, Maryland Fort Lincoln Cemetery 11/13/2010 4 Donation 5 Other (Specify) 21. Signature of Fan ral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. nolre 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Liver Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner History of Alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after cleath.

24 hours after cleath.

15 Hoursal Director: After this certificate has been signed by the attending physician and the prediction of the attending physician and the prediction of the property of the proper Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 5 Other (specify) Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension; Diabetes Mellitus 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ျ 1 🗌 Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide npleted filled in by determined City or Town, State) Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 10 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Lockwood Drive, Silver Spring, Maryland'

20901

10801

Registrar's Signature

M.D., ;

Jean Welsh,

31. Date filed (Month, Day, Year)

rank Caflisch		Please Type or Print in Bl			•	•	gible.	
Tank Camson		State of Maryland		nent of Health ar cate of Death	no iviental H	ygiene	2010	37558
Dhysisi	201	Registrar 1. Decedent's Name (First, Middle,Last)	Ochim	cate or beating		2. Date of Deat	eg. No.	3. Time of Death
Physici Medical Exami						Month November	Day Year	0905 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat	1
		1013 Stirling Road		Silver Spri	ng		Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last bi			. 8. Date of Birt	h (MM/DD/YYYY) 9. Bi	
Director		389-14-8120 1XM 2F	92	Yrs. Months Da	ys Hours Min	June 2	L, 1918 Foreign	ountry) WI
		Usual Residence of Decedent			1			
v any		10a. State 10b. County	10c. City, Tow	n or Location		_		10d. Inside City Limits
Maryland 28a-f show d at once.	ō	MD Montgomery	Si	lver Spring				1 Yes 2 No
Maryl 28a- d at c	Director	10e. Street and Number	-	10f. Zip Code		10	g. Citizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once.		1013 Stirling Road		2090	01		USA	
th wit	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>			14. Race - Amer White, etc.	ican Indian, Black,
er death	Fur	1 x Yes 2	No				Specify: What	ito
rs aft ural" mine	þ	15. Decedent's Education (Specify only highest grade com	VII	1 Yes 2 X N		vork done	Specify: Wn:	
2 hou "nat LExa	ted	Elementary/Secondary (0-12) College (1-4 or 5		during most of working life			rop. rand of Edomoso,	dustry
215-0036 be filed within 72 hours after death with the Maryland mall Hygiene. rked other than "natural", or items 23a or 28a-f she cut, the Medical Examiner must be notified at once	Completed	5+		Information Off	ficer		Federal G	overnment
5-0 ed wi fygier other	Cor	17. Father's Name (First, Middle, Last)			18.Mother's Name	(First, Middle, M	aiden Surname)	
21 be fil ontal H urked	Be	Frank Albert Caflisch			Bertha T			
D 2, hould nd Me is ma	٢	19a. Informant's Name/Relationship (Type, Print )		9b. Mailing Address (Stre				, Zip Code)
MI 2 salth a 27 raum.		John Stephen Caflisch/Son  20a. Method of Disposition		8116 Kerry Lane of Disposition (Name of ce	<u> </u>	Date MD 20	J815 20c. Location - City or	Tourn State
Ore, of He If ther th		1 Burial 2 X Cremation 3 Removal from Sta	orema	atory or other place) colitan Cremator	Nov.	. 9,	200. Location - City of	Town, State
timent trant:		4 Donation 5 Other Specify:	120101		20.	10	Alexandria,	VA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21 Signature of Funeral Service Licensee		22. Name and Addres	Collins Fund	eral Home	Inc.	_
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused	the death. Do n				Spring, MD 2090 st. shock, or heart	Approximate Interval
Medical.		failure. List only one cause on each line.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Exsanguination  Due to (or as a conse	equence of):					
		Sequentially list conditions, b. Multiple Injunes						
	ine	if any, leading to immediate Due to (or as a conse	equence of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a conse	equence of):	· · · · · · · · · · · · · · · · · · ·				<del> </del>
executed an and al - transit		d						
oe exe	dical	UNPENDED X AMENDED 28	Bb per i	ne g912 2-7-	11 vt			
ox 68760, eath certificate be exattending physician or use as the burial -	Physician/Med	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	ne of pregnancy				23d. Date of delivery	
certif	cian	past 12 months?	time of death	2 Fetal death 3 5 Other (Specify)	Ectopic pregna	ncy	Month D	Day Year
Box e death the atte	ıysi	1 Yes 2 No 9 Unknown g Unknown		United (Specify)			L	
O. lat the		Part II. Other significant conditions contributing to death	but not resulting	ng in the underlying cause	given in Part I.		pacco use contribute to	
P.C.	d by	Atherosclerotic Cardiovascular Disease				1 Yes	2 No 3 Prob	ably 4 Unknown
rds v requ	ompleted					24a. Was a autops		topsy findings available ompletion of cause of
ecc he lav ite has	Ĕ	*				perform	ned? death?	_
tal Rection: The	ပ	25. Was case referred to medical		26.Place	e of Death (Check o			
Vita	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatier	nt 2 ER/0	Outpatient 3 DOA	Other Nursing	Home 5 F	Residence 6 🗸 Other	: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be a proper page 3 should be a proper page 3 s		27. Manner of Death  1 Natural 5 Pending FOUND:	- n-1				ow injury occurred elf and then fell a	nainet heater
trendi freath.	atio	1 Natural 5 Pending FOUND:  Nov 7, 2010		UND: <b>8:55a</b>	Yes 2 V No	Jubject cut s		gamstriedter
ivis or A after of Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Inju	-	arm, street, factory, office t		or Town, Sta	reet and Number or Ru ate)	
Divisior Hospital or Attend 24 hours after death Funeral Directors		4 Homicide determined (Specify) Sing				1013 Stirling R	oad, Silver Spring, N	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	Check only one)  1 Certifying Physician: To the best of my one)  2 Medical Examiner:On the basis of examiner and manner stated.						
12+1	ž	29b. Signature and title of certifier	BOD	29c. Licens			29d. Date signed (Mor	
	1	/ Wolf valler feels		O.C.	M.E.		November 8, 201	0
	Ī	30. Name and address of person who completed cause of de		111 Page Ctural D	Politimana AAD (	21204		
	╝	Victor Weedn MD JD Assistant Medical	⊏xaminer	111 Penn Street, E	saitimore, MD 2	4 1207		

Registrar

			101	partment of Health and Menta ertificate of Death	Hygiene Reg. No.2 0 1 0 37	559
	Physicia	ın/	Decedent's Name (First, Middle, Last)	Mo	e of Death 3. Time	of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)  Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	# 4c. County of Death Montgomery	Α
į	Funeral Director		5. Social Security Number 6. Sex 1    1    1   1   1   1   1   1   1	If Under 1 Year   If Under 24 Hrs.   8. Date   Months   Days   Hours   Min.   (Moreover 1.5   Months	e of Birth nth, Day, Year) 1965 Mexico	or Foreign
	/aryland 8a-f show tified at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le  Maryland Montgomery Silver Sp		10d. Inside	City Limits
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 12126 Bluhill Road	10f. Zip Code 20902	10g. Citizen of What Country? Mexico	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1   Never Married 2   TrMarried   1   Ves 2   TrMa	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White	
Baltimore, Maryland 21215-0036	vithin 72 hou lene. er than "nat the Medica	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation  kind of work done duning most of working  DO NOT use retired)  CT	16b. Kind of Business Industry  Construction	
/land ;	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Ambrosio Fernandez Cruz	18. Mother's Name (First, Nicolasa Lazar	Middle, Maiden Surname)	
, Man	nd 2 shoul ealth and I m 27 is ma	0	Martha E. Jacobo / Wife 12126	ing Address (Street and Number or Rural Route Bluhill Road, Silver Sprin		
timore	Page 1 a Iment of H tant: If iter jury or oth		4 ☐ Donation 5 ☐ Other (Specify)	Miss cerritos November 1 2010	TEALDO	
Bal	permit Depar Impor any in	3		2. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd., W., S		
_	Ph_sician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Myocardial Infarction resulting in death)		tory arrest, Approxim Interval Bo Object and	etween
	Examiner	J.	Sequentially list conditions, b. Hypertension		Years	
	icate be executed physician and is the burial-trapsit	al Examiner	if any, leading to immediate cause. Enter through the cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Diabetes Mellitus  C.  Due to (or as a consequence of):		Years	
. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial rapsit	Physician/Medical		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day	Year
s, P.O.	uires that the signed by Id be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e	b. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱	
Record	The law requate has beer page 2 shou	Completed			a. Was an autopsy parformed?   24b. Were autopsy findings prior to completion of death?   2x No   1	
f Vital	sician: certific rector,		25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie 27. Manner of Death  28a. Date of injury 28b. Time o	, 1	e)  Residence 6 Other (Specify)  cribe how injury occurred	
O	ng Phys fter this ineral di		1 Natural 5 Pending (Month, Day, Year) injury	work?		
ivision c	Il or Attending Physician: affer death. Director: Affer this certific d in by the funeral director.	Certificate:	1	work?  M 1 ☐ Yes 2 ☐ No  reet, factory, office 28f. Loca	ation (Street and Number or Rural Route Num or Town, State)	ber,
Division of Vital Records,	the Hospital or Attending Phys hin 24 hours after death. the Funeral Director. After this npleted filled in by the funeral di		2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, str building, etc. (Specify)  29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	work?  I □ Yes 2 □ No  reet, factory, office  28f. Loc. City  occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to occurred at the time, date and place, and due to occurred at the time, date and place, and due to occurred at the time, date and place.	or Town, State)  the cause(s) and manner as stated. date and place, and due to the cause(s) and manner as stated.	
Division	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2:	Certificate:	29a. Certifier (Check only one)  29b. Signature and title of certifier  (Check 20b) (Check only one)  (Check 20b) (Check only one)  (Check one)  (Check only one)  (Check only one)  (Check only one)  (Check only	work?  1   Yes 2   No  reet, factory, office  28f. Loc. City  occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to courred at the time, date and due to courred at the time, date and due to courred at the time, date and due to courred at the	or Town, State) the cause(s) and manner as stated. date and place, and due to the cause(s) and m	
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral di	Certificate:	29a. Certifier (Check only one)  29b. Signature and title of certifier    Accident   Investigation   Could not be determined	work?  1  Yes 2 No  reet, factory, office  28f. Loc. City  occured at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to courred at the time, date and place, and due to courred at the time, date and place, and due to courred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, in my opinion, death occurred at the time, date and place, and due to stigation, death occurred at the time, date and place, and due to stigation, death occurred at the time, date and place, and due to stigation, death occurred at the time, date and place, and due to stigation, death occurred at the time, date and death occurred at the time, date and due to stigation, death occurred at the time, date and due to stigation, death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date	or Town, State)  the cause(s) and manner as stated. date and place, and due to the cause(s) and me to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)	

		•	for State of M. State of M. State of M. RG Registrar	aryland FCHD	d / Depa 11/ <u>-12</u> <i>Cei</i>	artment of H Tilicate of D	eaith and M <i>eath</i>	lental Hygie Rea	ene J. No.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Mildred Louise					2. Date of Death	27 201	3. Time of Death U 0 7:54 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4602 Pinewood Trail	0111	-	4b. City, Town, or I	Location of Death		4c. County of Dea	
	Funeral			e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bi	rthplace (State or Foreign
	Director		Usual Residence of Decedent  10a. State 10b. County					(Month, Day, Ye 4/5/19	129	MD
	Marylan 28a-f sh otified a	irecto	MD Frederick	TOC. City,	, Town or Lo	Middleto	own			10d. Inside City Limits  1X∑ Yes 2 □ No
	with the 23a or 3ust be no	Funeral Director	10e. Street and Number 25 Walnut St.			10f. Zip Code 217	769	10g	g. Citizen of What C	ountry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent E Armed Forces?  1 ☐ Yes 2√2 ☐ If Yes, Give Year or Dates.		1	Was Decedent of His f Yes, specify Cuban I ☐ Yes 2 ☑No	, Mexican, Puerto F		14. Race - Ame Black, Whi Specify: Wh	te, etc.
215-0	רס 72 hou. an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5		(Give	dent's Usual Occupa kind of work done du O NOT use retired)		ng   16	6b. Kind of Business	Industry
d 212	ed withir Hygiene other th ent, the	Be Co	17. Father's Name (First, Middle, Last)		se	wing	18. Mother's Name	(First, Middle, Mair	tailor	СО
rylan	uld be fil d Mental marked natic ev	알	Ira Cline				Mary G1	adhill		
, Ma	nd 2 sho ealth and m 27 is i		19a. Informant's Name/Relationship (Type, Print)  Donald Cline (Nephew)			Pinewoo				MD 21769
Baltimore, Maryland 21215-0036	. Page 1 at timent of H tant: If itel jury or oth		20a. Method of Disposition  1 □XBurial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	ce	meterv. cren	sition (Name of natory or other place Cemeter	9) !		c. Location - City o	
1 POB 16, MIddletown, MD 21769										
23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.  The disease or condition fesulting in death)  A plus to (or as a complete of the condition of										Approximate Interval Between Onset and Death
	Examiner	Metartatic Carcinoma								
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0	icate be executed physician and is the burial-transit	edical E	resulting in death) Last Due to (or as a	a conseque	ence of):					
3876	rtificate ing phy e as the	/Med	IF FEMALE:	,	277				1/	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
ls, P.O.	requires that the des been signed by the a should be detached t	by	Part II. Other significant conditions contributing to death b	1	liting in the u	1	en in Part I.			o the cause of death?
Recor	rsician: The law rec s certificate has bee lirector, page 2 sho	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
ital	Physician: The lav r this certificate has aral director, page 2	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 postion			_ Other	ce of Death (Check	/		Nephew's Home
of V	ing Phys	ate: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  1 ☑ Natural 5 ☐ Pending	y 2	28b. Time of injury	28c. Injury a work?	at 2	ne 5 ET Heeidene 8d. Describe how i	e 6 Other (Specinjury occurred	ify) 1 Home
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director, After th completed filled in by the funeral	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injubiliding, etc		ne, farm, stre		res 2 □ No	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	e Hospita 24 hours e Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of only one)  3 Certifying Nurse Practioner: To the	kamination .	and/or invest	igation, in my opinion	, death occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.
	To th within To th comp	~	29b. Signature and title of certifier	1)	$\circ$	29c. License		29d.	Date signed (Mont	h, Day, Year)
	T)		30. Name and address of person who completed cause of de	eath (Item 2	23a) (Type, P	rint) Fredy	rihme	21702	-	
	Stat Registra		31. Date filed (Month, Day, Year) 12 2010 32. Registra	s Signatu	ire	backer				
_										

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ivial ylan		tificate of Dea			Reg. No.			
	Dhysisis	n/	1. Decedent's Name (First, Middle, Las	t)		2. Date of Month						
	Physicia Medio		Robert O. Carso					Novembe	er 🦻 20	010	6:00 AM	
	Examin	er	4a. Facility Name (if not institution, give Premier Assisted			4b. City, Town, or Loc Bowie	cation of Death			nty of Death ce Geo1	caola	
-	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birt	h	g. Birthpl	lace (State or Foreign	
	Director		<u>231–44–9648</u>	<b>⊠</b> M 2 □ F 73	Yrs.	Months Days H	lours Min.	(Month, Day Sept 18	y, Year) 3 1937	Virgi	nia	
	nd how at	ř	Usual Residence of Decedent									
	farylar Ba-f s tified	ecto	MD Prince Ge	orge's	Bow:	ie					1 🔯 Yes 2 🗌 No	
	the N	اقا	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Count	try?	
	h with	Funeral Director	11000 Lake Arbor			20721			US	SA		
	r deat	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	12. Was Decedent Ever in U.8 Armed Forces? 1 ☐ Yes 2 🕱 No	S. 13. \	Was Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Sped Mexican, Puerto F	cify Yes or No- Rican, etc.)		Race - America Black, White, e		
036	rs afte rral", o Exam		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	∣ Yes 2 🛛 No S	Specify:		Spec	cify: Blac	k	
5-0	2 hou "natu edical	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occupation	n ng most of workir	ng	16b. Kind o	f Business Ind	lustry	
121	ithin 7 ene. • than	S E	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired) pco Linemar			T	Pepco		
d 2	lled w I Hygi other	Be	17. Father's Name (First, Middle, Last)	Unknown	1 10		3. Mother's Name	(First, Middle,				
/lan	d be f Menta arked ttic ev	잍					Roberta	Claytor				
lan	should and h is ma		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street and	Number or Rural	Route Number	r, City or Towr	n, State, Zip C	ode)	
e, €	and 2 dealth sm 27 ther tr		Phyllis Williams 20a. Method of Disposition			O Lake Arbo				0721		
nor	age 1 ant of H		1 🔲 Burial 2 🗵 Cremation 3 🗆	Removal from State	emetery, cren	sition (Name of natory or other place)		ate 7./10		on - City or Tov		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) Fort Lincoln Crematory 11/17/10 Brentwood, Md  21. Signature of Funeral Funeral Home									
m	Depar Impol any ir		Dreiamar	cis		401 Bladens					722	
23a. Part 1. Enter the difference of the second sec									Interval Between			
Immediate Cause (FV al disease or condition resulting in death)  A Medical  Immediate Cause (FV al disease or condition resulting in death)  a. Due to (or as a softenum result)								Onset and Death				
1	Examiner		Due to (or as a consequence of):									
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	dence of).	MICE		- 0		_		
	cuted nd rransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								SC-		
	oe execian a		resulting in death) Last	Due to (or as a consequence	uence of):							
8760	ath certificate be executed attending physician and for use as the burial-transit	<b>dedical</b>		d								
89	n certif ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta		Ectopic pregnancy			23d.	Date of delive	ry	
Вох	death the att	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of a		Other (specify)			Month Day Year			
Ö.	requires that the des been signed by the s should be detached		Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	inderlying cause given i	in Part I.	23e, Did to	obacco use co	use contribute to the cause of death?		
S, F	rires the signer of the signer	d by	the phin	1 🗆 '	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
ord	w requ	plete	alane	ma				24a. Was			sy findings available	
								perfo	autopsy prior to completion of cause of death?  1 □ Yes 2 ☒ No 1 □ Yes 2 □ No			
tal	cian: ertifica ector,	Be (	25. Was case referre to hedical examiner?	Linea itali		1.	of Death (Check	_				
ίV	Physic this c	욘	1 Yes 2 No	Hospital: 1  Inpatient 2  28a. Date of injury	ER/Outpatier		4 Nursing Hor					
o u	nding tth. : After e fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work?	2 🗆 No	28d. Describe n	ow injury occ	w injury occurred		
risio	I or Attending Physician: The la after death. Director: After this certificate ha i in by the funeral director, page.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined			eet, factory, office	1		(Street and Number or Rural Route Number,			
Ď.	ital or urs aft ral Die lled in							City or Tow			10	
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Exami	sician: To the best of my know ner: On the basis of examination	n and/or invest	tigation, in my opinion, c	death occurred at	the time, date a	nd place, and	due to the cau	ise(s) and manner stated.	
	To the within To the compl	Σ	only one) 3 Certifying Nurs  29b. Signature and title of certifier	e Practioner: To the best of m	y knowleage, (	29c. License nu				manner as sta gned (Month, D		
	3		HAMIS	MD		1000	6541	8	11/1	0/10	7	
	01		30. Name and address of person who o	completed cause of death (Item					17	l	20740	
	Total		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture .	01 Greenbel	It Rd Su	ite M-	L/ Co.	llege F	rk, Md	
	Sta Registra		NOV 1 2 2010	Anna S.	back							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:06 P<sup>M</sup> Junior Casteel November 4, 2010 Clarence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) August 24, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1932 Webster Spring, 78 Director 234-44-1010 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the two context must be notified at 1 X Yes 2 □ No MD Prince Georges Bowie Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural" or iteman any injury or other trainment. 15803 Pinecroft Lane 20716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 XYes 2 No 1951 If Yes, Give
Year or Dates: 1954 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 💢 No White Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pepco Power Company  $\overset{\text{Elementary/Secondary (0-12)}}{10}$ College (1-4or 5+) Lineman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence J. Casteel Alice L. Murphy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15803 Pinecroft Lane Geraldine Casteel/ Wife Bowie, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Damon Cemetery Newburg, WV 11/9/10 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licens CANTE 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date, signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number f person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Year) 32. Registrar's Signature 31. Date filed (Month, Day, State NOV 082010

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

		4	FOR	partment of Health and ertificate of Death		2010 37563
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. N	3. Time of Death
	Physicia	n/	Vivian Lee Cross			Вау 2010 <sup>ear</sup> 3:00 Рм
	Medic Examin	_	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h 4	4c. County of Death
			4706 Lisborough Terrace	Bowie  If Under 1 Year   If Under 24 Hrs	100 100	Prince George's  9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number  237-04-7453  6. Sex 1	Months Days Hours Min.		957 North Carolina
4	w	. h	Usual Residence of Decedent	1 4:		10d. Inside City Limits
	yland -f shc ed at	cto	10a. State 10b. County 10c. City, Town or	Location		1X Yes 2 □ No
	e Mar r 28a notifi	ig l	MD Prince George's Bowie  10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
	ith th	la	4706 Lisborough Terrace	20720	l °	USA
	ath w	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Armed Forces?  1★☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☒ No  If Yes, Give  Year or Dates.	If Yes, specify Cuban, Mexican, Puerl  1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	Black, White, etc. Specify: Black
8	nours atura cal E	ete	15. Decedent's Education 16a. De	ecedent's Usual Occupation	, 16b	b. Kind of Business Industry
212	n 72 h s. an "n Medi	Completed	U.F.	live kind of work done during most of wo e. DO NOT use retired)		_ =
7	withi giene ner th		Elementary/Seconday (0-12) College (1-4 or 5+)	memaker		Domestic
pu	e filed	To Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Maide 7S <b>CYOSS</b>	ən Surname)
<u> </u>	uld by d Mer mark natic	-	James Williams, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. N	Mailing Address (Street and Number or Re		or Town, State Zin Code)
Ma	2 sho th and 27 is I			706 Lisborough Terr		e, MD 20720
ē,	I and f Heal item		20a. Method of Disposition 20b. Place of D	isposition (Name of	Date 20c	Location - City or Town, State
mo	age ient o		1 🛣 Burial 2 □ Cremation 3 🛣 Removal from State 4 □ Donation 5 □ Other (Specify) Glennvi	ew Mem. Gards. 11/	11/2010	Durham, NC
Baltimore, Maryland 21215-0036	permit. F Departm Importa any inju once.	l	21. Signature of Funeral Santice License	22. Name and Address of Facility	seall funera	
<u> </u>	9 9 E 8 9	Ш	/ pu	6512 NW Crain Hwy.		
			23a. Part . Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause or each line.	I control of the second	c or respiratory arrest,	Approximate Interval Between Onset and Death
1	mysician/ Medical		a	iek caneer		
	Examiner		resulting in death)  Due to (or as a consequence of):			
		Jer	Sequentially list conditions, The tolor as a consequence of cause. Enter Underlying			
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.			
	exectian an	Ě	resulting in death) Last Due to (or as a consequence of)			
9	cate be executed physician and s the burial-transit	dical	d			
587	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	*		23d. Date of delivery
Box 687	ath ce attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?   1   Live Birth 2   Fetal death   1   Yes 2   No   No   No   No   No   No   No	3  Ectopic pregnancy 5 Other (specify)		Month Day Year
Э.	the de sy the ached	hysi	g Unknown			
P.O.	r requires that the death certificat been signed by the attending ph should be detached for use as the	ğ	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.		co use contribute to the cause of death?  2   No 3   Probably 4   Unknown
rds	equire een si nould	sted			24a. Was an	24b. Were autopsy findings available
of Vital Records,	The law rate has b	Completed			autopsy performed	prior to completion of cause of
Ä	ician: The certificate rector, pag		.25. Was case referred to medical	26, Place of Death (Ch		No 1 Yes 2 No
/ita	Physician: 7 r this certifica ral director, p	To Be	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Othori	Home 5 Residence	e 6 Other (Specify)
of \	g Phy er this neral c		27. Manner of Death 28a. Date of injury 28b. Tir		28d. Describe how in	
on	ttendin death. ctor: Aff y the fur	fica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No		
Division	II or Attending P safter death. I Director: After t d in by the funera	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farn building, etc. (Specify)	ı, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
۵	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do (Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurre	d at the time, date and pl	lace, and due to the cause(s) and manner stated
	the H hin 24 the Fi	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowled	dge, death occurred at the time, date and p	place, and due to the cau	use(s) and manner as stated.  Date signed (Month, Day, Year)
	<b>라</b> wit		29b. Signature and title of central and title of ce	D0070102		1-08-2010
U			30. Name and address of person who completed cause of death (Item 23a) (Ty		0 1	, 00
U	43		Dr. Ivan Zama M.D. 9200	Basil Ct. Ste.	100 Large	o, ma 20774
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 1 0 2010  32. Registrar's Signature	parker	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7 Physician/ Katherine W. Collison November 2010 5:15 Medical 4c. County of Death Anne Arundel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner South River Health and Rehab Center Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country) Maryland **Funeral** Hours 1 □ M 2 🔽 F 99 219-16-0263 1271171910 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Edgewater Maryland Anne Arundel 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21037 144 Washington Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2x X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Completed 3 K Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Levy ပ Daniel W. Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 118 Valley View Ave., Edgewater, MD 21037 19a. Informant's Name/Relationship (Type, Print) Karl R. Collison - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of St. Mary's Cemetery 11/12/2010 1 X Burial 2 Cremation 3 Removal from State Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licens 147 Duke of Gloucester St., Annapolis, MD 21401 Midlin T. Woher 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death aryth mis Immediate Cause (Final Carellac total Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI) DUU53709 NOV 8Th 2010 cun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Gallant Fox love STE # 210 14300 HAWLH 31. Date filed (Month, Day, Year) 32. Régistrar's Signature NOV 09 2010 State Registrar

37565

			1 - State Registra AMEND#23 openMD	,11/10/10,BM	N,MbCc	. Cer	tifica	te of L	Death		Red	9. No.			
	Dharisis	/	1. Decedent's Name (First, Middle, Las	t)							of Death		16	3. Time of De	eath
	Physicia Medio		Edward Franci	s Doughe	rty					Noven	iber 4	, <sup>D</sup> 2010	Year	6:35 P	M
Examiner			4a. Facility Name (if not institution, give			Location of De	eath		4c. County						
			Sanctuary at Holy Cross Burt									Mont	gomery		
	Funeral Director		200-20-7449	7. Age	83	st birthday) Yrs.	Months	er 1 Year Days			of Birth oth, Day, Ye	1927		lace (State or First) Sylvania	oreign
	how at	5	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside										0d. Inside City I	Limits	
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	vith the N 23a or 28 st be not	<b>Funeral Director</b>	10e. Street and Number 420 Hawkesbury Lane				10f. Z	ip Code 2090	)4		10	g. Citizen of V USA	Vhat Coun	try?	
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Baltimore, Maryland 21215-0036	ld be file Mental H arked ot atic ever	<b>To E</b>	Edward Joseph Dougher	ty		1				Name (First, M Lillian			)		
	nd 2 shou ealth and n 27 is m		19a. Informant's Name/Relationship (Ty Mary Dougherty / Wife			19b. Mailir <b>420</b> H	ng Addres awkes	ss (Street a bury I	and Number or ane, Sil	Rural Route N ver Spri	lumber, Ci ing, M	ty or Town, Si D 20904	tate, Zip C	ode)	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiurry or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 3 🗍  4 🗍 Donation 5 🗍 Other (Specify		Çe	lace of Dispo emetery, cren of Hear	natory or	other plac	e) Y Nove	Date mber 8,		oc. Location - Silver	-		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service/License	rento		22	Franc 500 U	nd Addres 15 nivers	cofilins city Blvd	Funeral	Home, Silver	Inc. Spring,	MD 20	)901	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused	the death	. Do not ente	er the mo	de of dyin	g, such as card	liac or respirat	ory arrest,		-	Approximate Interval Between	00
- 1	nysician	8 1	Immediate Cause (Final disease or condition			ed d	om	anti	2.					Onset and Dea	
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	g - 1	Examiner	if any Leading L. immediate Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury)												
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8760	rtificate ing phys as the	Medical		d								_			
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). Box	the death by the atte	Physician,	1 Yes 2 No	4  Pregnant at 9  Unknown	time of de	eath 5□	Other (	specify)				Mor	nth I	Day Yea	ır
s, P.O	requires that the death cer been signed by the attendi should be detached for use	ρ	Part II. Other significant conditions co	ntributing to death bu	it not resu	ılting in the u	nderlying	cause giv	ren in Part I.	23e.				e cause of deat	
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₹	Physi this c	<u>1</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatie		ER/Outpatien 28b. Time of			4 Nursin	g Home 5					
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Division of	To the Hospital or Attending Physiciam:  Within 24 hours after death of the Funeral Director. After this certification in the funeral director, the funeral director director, the funeral director, the funeral director director, the funeral director directo	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	me, farm, stre				tion (Street and Number or Rural Route Number, or Town, State)							
۵	Hospital Hospital Funeral	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examir	ician: To the best of ner: On the basis of ex	ny knowle amination	edge, death o	occured a	t the time,	date and place	e, and due to t	the cause(	s) and manne	r as stated	I. se(s) and manne	er stated.
	thin 2 the 1	Ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the b	est of my	knowledge, d	leath occ	urred at the	time, date and	place, and du	e to the ca	use(s) and mai	nner as sta	ted.	
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,	,		30. Name and address of person who co	ompleted cause of do	ath (Item	23a) (Tuno D	rint)	1300	16780	X (	· ·	1-3-1			-
			and the same of th	1 , 2835 S				410:	203-B.	Ball	min	e M	0.		
	Stat		31. Date filed (Month, Day, Year)	32 Registrar			2	1	201	- 5500					
	Registra	ar .	MOA I II ZUI	1 / hi seed	20 L	23953	1000	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlotte Elizabeth Dann 2010 November 12:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Arden Courts Assisted Living Kensington Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min May 30, 1 M 2 M 577-28-5187 Wash DC Director 89 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Examiner must be notified or 28a-f MD Chevy Chase Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20815 United States 8100 Connecticut Avenue #1521 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Library Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clara L. Harrison Carroll A. Warthen permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Connecticut Ave. #1521 Chevy Chase, MD 20815 Clayton S. Dann / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State National Crematory 11/06/2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Funeral Service Licens 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Advanced Alzheimer's Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ttendir g physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the d g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Assisted examiner?

1 Yes 2 X No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) Living After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide completed filled in by determined City or Town, State 24 hours Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-27660 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

NOV 09

Alpana Goswami MD 11125 Rockville Pike Suite 110 Rockville, MD 20852

32 Registrar's Signature

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2010 0141 ROBERT DARRINGTON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug 7, 1940 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₺ M 2 □ F Min. Hours TX Director 571-54-0616 70 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Charles Waldorf 1 Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20602 2004 Wingate Ct. USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. þ 1 Never Married 2 Married 1963 1<u>965</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lucent Technologies oith and Mental Hygien 27 is marked other the traumatic event, the 12th Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Annie Bell Darrington permit. Page 1 and 2 should be Department of Health and Merr Important: If item 27 is marke any injury or other traumatic once. Herman Darrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 Whirlaway Dr. Midlothian, VA Robert Wayne Darrington-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Quantico National Cem 11-15-2010 Triangle, VA 21. Signature of Uneral Service Licenses 22 Name and Address of Facility Funeral Home of Maryland Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE Records. RENAL 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 🗶 No မ 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1)0048123 Lugus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTWI-DONKOR ERIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

State Registrar 1818

31. Date filed (Month, Day, Year)

**PISCATAWAY** 

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b, c, e, f, perINF, G910, 12/10/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October John Arthur Davies, Jr. 2010 8:20  $A^M$ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Loch Raven VA Community Living/Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-50-8519 Davs Hours Min. 1XXM 2 □ F 61 3/11/1949 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director Maryland Cecil Port Deposit 1 Yes 2 No Glen Burnie **Anne Arundel** 10g. Citizen of What Country? 10e. Street and Number 425 Cokosbury Rd. P.O. B 301 Rain Water Way Unit 304 10f. Zip Code 21904 U.S.A. Funeral 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 XX Never Married 2 Married XX Yes 2 No White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Vietnam 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) B&O Railroad Foreman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ John A. Davies, Sr. Ruth E. Custer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Davies/brother 8218 Champion Ct. Pasadena, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Hillcrest Mem. Gardens 11/2/2010 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Squamous Cell Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and l-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Veat 5 Other (specify) Pregnant at time of death 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3XXProbably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 XXIIo 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4XXNursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 🗌 Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA ျှ within 24 hours after death.

To the Funeral Director: After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury XX Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 XXC ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch Raven Blvd. Debra S. Wertheimer, MD Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State NOV 092010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra MFND#29apenMD, 11/12/10, BMW, McCo Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Year Margaret M. Edwards November 4 9:10 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 😿 F Director Yrs. 087-22-4403 88 May 7, New York Usual Residence of Decedent 28a-f shov 10a. State 10b. County than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 3423 S. Leisure World Blvd. 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify.White 3 ₩ Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Executive Research marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Arthur McShane Mary Agnes Nolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other trau Anne Mary Edwards/Daughter 619 Greenbrier Drive, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dec 2010 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia Prancis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd. W., Silver Spring, MD 20901 D 23a. Part 1. Enter the disease, 2 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. L'it only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ east disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of) transit. The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? performed' this certificate Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🖰 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural work? 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 X Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00064624 11/08/2010 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMMER WALK DR. GALTHERSBURG, MD SANDEEP SHARMA 743

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Felleke November 6, 10:50 a . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 814 Kenbrook Drive Social Security Number 9. Birthplace (State or Foreign Country) Ethiopia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 25, 1930 **Funeral** 1**X** M 2 F Months Days 228-33-7375 80 Yrs Director Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖰 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 814 Kenbrook Drive 20902 filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Military Officer Armed Forces Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Askale Shishegu Felleke Melke

Physician/ Medical

that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: 24 hours after death.

Examiner

19a. Informant's Name/Relationship (Type, Print)

Linda H. Goldstein, MD

31. Date filed (Month, Day, Year)

NOA

1	Senait Gizaw/Wife	814 K	Kenbrook Drive, S	Silver Spring,	Spring, MD 20902						
	20a. Method of Disposition  1 ★ Burial 2 Cremation 3 Removal from State 4 Donation 5 Cther (Specify)		position (Name of rematory or other place) reaven Cemetery	natory or other place) Nov. 11.							
	21. Signature of Funeral Service Licensee	H	22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901								
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition  Metastatic	nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.  a. Metastatic Colon Cancer  Due to (or as a consequence of):									
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or improv	b. Due to (or as a consequence of):  Due to (or as a consequence of):									
dical Exa	that initiated events resulting in death) Last  C. Due to (or as a d.	C. Due to (or as a consequence of):  d.									
Completed by Physician/Medical Examiner	IF FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of out the past 12 months?   1										
ed by PI	Part II. Other significant conditions contributing to death bu	o the cause of death?  Probably 4 🔀 Unknown									
Complet		autopsy findings available o completion of cause of ? 'es 2 🗌 No									
To Be	25. Was case referred to medical examiner?			26. Place of Death (Check only one)							
<u>P</u>	Hospital: 1										
ficate:	27. Manner of Death  1X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Year) 28b. Time injury			d. Describe how injury occurred						
al Certi	4 1 taminide determined 28e. Place of Injur										
Medical Certificate:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	29b. Signature and title of certifier		29c. License numbe D3504		29d. Date signed (Mont Nov. 10, 20	Date signed (Month, Day, Year)  Vov. 10, 2010					
1	20. Name and address of person who completed cause of de	oth /Itom 22n) /Time	Print\								

4601 North Park Avenue, Chevy Chase, MD 20815

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DHMH 17 Rev 7/2009

State

Registrar

10

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Physician/ Month 11/06/2010 Dino Ernesto Flores 5:10 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9455 Newbridge DR Montgomery

9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs. 8 Date of Birth **Funeral** (Month, Day, Year) 3/15/1930 1 🖾 M 2 □ F Director 216-42-5198 80 Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f 1 X Yes 2 No Md Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 9455 Newbridge DR 20854 US 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 5 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Completed 3x Widowed 4 ☐ Divorced Peruvian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Doctor Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernesto Flores Grimanesa Perez 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dino Flores Jr / Son 8416 Grossnickle CT Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) National Crematory 11/09/2010 Falls Church, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ oncultic concer METAJTATIC disease or condition NONNI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No as been signed by the 2 should be detached a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERITONSIUN 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? this certificate 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 No Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pendina s after death. ☐ Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25256 108 2010

DHMH 17 Rev 7/2009

State

Registrar

10 Mich

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

TOJE A. 1001,005 IMD 43 43 MONTCO MERY AV BENTESDA MD

3. Registrar's Signature

Wulnus

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31. Date filed (Month, Day, Year)

10-08600 Leslie Files, II		Please Type or Print in Bl						jible.	
Lesile i iles, ii		State of Maryland			or Health ar of Death	na ivientai i	7.5	2010	37572
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		- Imouto t	Death		Re 2. Date of Deat	g. No. — O i O	3. Time of Death
Medical Exami	ner	Leslie Thomas FILES II					Month November	Day Year 9, 2010	1225 hrs
		4a. Facility Name (if not institution, give street and number)				or Location of Dea	ath	4c. County of Deat	h
		17719 Timberlane Drive			Hagerstow			Washington	
Funeral Director			-	ast birthday)	If Under 1 Ye Months Da		lin	h (MM/DD/YYYY) 9. Bi	gn
	ŀ	213-72-8925   1 X M 2 F   Usual Residence of Decedent	53	Y	rs.		Nov. 2	9, 1956 c	ountry) Maryland
any	ı	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
Maryland 28a-f show	ь	Maryland Washington		Hage	rstown				1 Yes 2 X No
Maryl - 28a-1	Director	10e. Street and Number			10f, Zip Code		10	g. Citizen of What Cou	intry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		17719 Timberlane			1	740		USA	
ath wi	Funeral	11. Marital Status 12. Was Decedent 1 Never Married 2 Married Armed Forces?			/as Decedent of H Yes, specify Cuba	ispanic Origin? ( an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
ter de:		3 Widowed 4 X Divorced of Pates:	No	<sub>5</sub>   <sub>1</sub>	Yes 2X N	o specify:		Specify: W	hite
ours af ttural amin	Completed by	15. Decedent's Education (Specify only highest grade con		16a. Decede	ent's Usual Occup	ation (Give kind o		16b. Kind of Business	
6 172 ho cal Ex	ete	Elementary/Secondary (0-12) College (1-4 or	5+)		most of working lif		etired)		
003 within iene.		12 0		fork	lift dri			warehouse	
15. filed all Hyged other	Be C	17. Father's Name (First, Middle, Last)  Leslie Thomas Files					me (First, Middle, M	,	
212 uld be Ments mark		19a. Informant's Name/Relationship (Type, Print )		19b. Maili	ng Address (Stre	eet and Number o	C. Rohr	er ber, City or Town, Stat	e. Zip Code)
MD 21215-0036 d 2 should be filed within 1 tht and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u>		Mary C. Files - mother						town, Md.	
Te, I and I and Health	Ī	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from St		Place of Disportenatory or o	osition (Name of co	emetery,	Date	20c. Location - City o	r Town, State
Baltimore, bearmit. Pages I an Department of Hel Important: If ite		1 X Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	110	-	1 Cemete:	ry   11	/13/10	Hagerstov	vn, Maryland
Salti ermit epartn nports	ı	21. Signature of Funeral Service Licensee	(	22	Name and Addres	ss of Facility	MINNICH	FUNERAL HO	•
	_	23a. Part I. Enter the disease, or complications that caused	-	4	15 E.Wil:	son Blvd	Hagers	stown, Md.	21740
Physician /Medical		failure. List only one cause on each line.				3, such as cardiad	or respiratory arre	st, snock, of heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic  Due to (or as a const			sease				Death
		Sequentially list conditions, b							
	iner	if any, leading to immediate Due to (or as a conscipulate. Enter Underlying Cause	equence of	f):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	equence of	f):					
executed ian and ial - transit	ical E	d							
O, be ex sician		UNPENDED AMENDED		_					
.O. Box 68760, that the death certificate be ned by the attending physici detached for use as the buri		F FEMALE:  3b. Was decedent pregnant in the 23c. If yes, outcor	ne of pregr		etal death 3	Ectopic preg	nancv	23d. Date of deliver	ry Day Year
X 6. th cert the cert trending fruse a	icia	past 12 months?	time of dea	ath -	Other (Specify)		, idi.ioy	Mortui	Day Teal
Bc. Bc he dea y the a hed fo	چ	Unknown					Los pitti		
j, P.O. Barres that the designed by the	ò	Part II. Other significant conditions contributing to deat	n but not re	esulting in the	underlying cause	given in Part I.		bacco use contribute to	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that its after death.  *al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaa	Completed						24a. Was a		utopsy findings available
tal Records cian: The law requi certificate has been :	ם						autops perform	sy prior to	completion of cause of
Rec a: The l tificate l or, page		25. Was case referred to medical	_		26 Plac	ce of Death (Chec		2 No 1 Y	es 2 No
Vital   ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2	ER/Outpatie		Othor		Residence 6 🗸 Othe	er: Scene
of Vining Physical After this	<b>-</b>	27. Manner of Death 28a. Date of Inju	iry ear)	28b. Time o	Injury 28c. Inj	ury at Work?		ow injury occurred	
ion itendi leath. tor: /	agi	1   Natural 5 Pending 2 Accident Investigation (Month, 24), 1	July 1		1_	Yes 2 No			
Division of Pipital or Attending Phous after death.  Terral Director: After Iffiled in by the funeral	Certification:	3 Suicide 6 Could not be 28e. Place of In	jury - At ho	me, farm, str	eet, factory, office	building, etc.	28f. Location (S or Town, St		ural Route Number, City
Hospital 24 hours Funeral tely fillec		4 Homicide determined (Specify)							
	Medical	consider the control of the best of monopole (Check only one)  Certifying Physician: To the best of monopole of the best of monopole of the best of examiner: On the basis of examiner.	y knowledo mination ar	ge, death occ nd/or investig	urred at the time, o ation, in my opinio	date and place, a on, death occurred	nd due to the cause d at the time, date a	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To the within To the comple	Med	and manner stated.  29b. Signature and title of certifier				ise number		29d. Date signed (Mo	
		In he. V.				.M.E.		November 12, 2	
フォト	-	30. Name and address of person who completed cause of d	leath (Item	23a)					
6		Ling Li, MD Assistant Medical Examine	r 111			, MD 21201			
	ate	31. Date filed (Month Day, Year) 2010 32. Fegistra		rey de	arted				
Regist	iai	447.4		-	TO STATE OF THE ST				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Josephine V. Grimaldi 1209 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, Feb. 25)
 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months 579-36-0753 Country) 79 Vrs Director Feb Ĩ931 Usual Residence of Decedent 28a-f shov 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2725 Weller Road 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: White 3 -Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working ified within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Medical Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be 1
Department of Health and Menta
Important: If item 27 is marked
any injury or other traumatic ev ပ Edward Totaro Grace Totaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Reuther/Daughter Olney Mill Court, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 12 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven 2010 Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Francis J. Collins
500 University Blvd. Signature of Funeral Service Licensee ueneral Home W., Silver Spring, Mu F 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition HYDUX19 HOUS Medical resulting in death) Due to (or as a consequence of): Examiner Hyperca Sign Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): executed the burial-trace attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş page 2 should be (1) GOTTE GRENYSM REGIN Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? COPP 24a. Was an has autopsy perform Renal HEILUM 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after dea... al Director: After 1 🗹 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check diet the time, date and place To the 31 Certifying Nurse Practioner To the best of my knowledge death occurs 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) 2 066562 11/8/2010 MN amounto

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mauno Sarmiento, MD 8600 Old Georgetown Road, Bethesda, MD 20814

			ase Type or Pr			ndelible Inl artment of H		•		egible.	
	-	For State RegistrarAMEND#10/b+1		-				•	Reg. No.	110	37574
Physicia	n/	1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
Medic	al	ALI 4a. Facility Name (if not institution	FRED N.	GER	ALD	4h City Tourn or	Location of Death	NOVEMB	ER 6,	2010	<del></del>
Examin	er	RENAISSANCE (					ER SPRIN		- 1	unty of Death PRTNCE	GEORGES
Funeral		5. Social Security Number			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Year)	9. Birth	nplace (State or Foreign
Director		075-18-0057 Usual Residence of Decedent		91	Yrs.			SEPT. 1	7,191	9   PA	NAMA
yland f show	ģ	10a. State 10b. County	E GEORGES	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
e Mar r 28a- notifie	Director	MD • — MON I	FGOMERY-	L.		SILVER S	PRING				1 ¥ Yes 2 □ No
death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral		FIELD RD. #2	101		10f. Zip Code	904			of What Cou	intry?
items		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp		14.	Race - Amer	
after al", or xamir	d b	1 ☐ Never Married 2 ☐XMar 3 ☐ Widowed 4 ☐ Divorced	med 1 ☐ Yes 2 🗶 If Yes, Give	No No		Yes 2X No	Specify:	or moun, etc.,		Black, White	
hours natura dical E	lete	15. Decede	nt's Education			lent's Usual Occup			16b. Kind	of Business In	LACK
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1 and of Heal item 2		DOROTHY GERA  20a. Method of Disposition			lace of Dispo	GRACEFI sition (Name of		F2101, S		SPRIN ion - City or 1	G, MD.20904 Town, State
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permit. Departr Imports any inju		21. Signature of Funeral Service I	Licepsee	D	22	Name and Addres HAMBERS	FUNERAL 1	HOME & C	REMAT	ORIUM,	P.A.
H H = 6 0	$\dashv$	23a. Part 1. Enter the disease, or	complications that cause		091   5	801 CLEV	ELAND AV	E., RIVE	RDALE	, MD.	20737
Physician/		shock, or heart failure. List of Immediate Cause (Final	only one cause on each lin	ie.					001,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	Due to (or as			ARDIOVAS	CULAR DI	DEADE		-	
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9 E E	_	that initiated events resulting in death) Last	Due to (or as	a consequ	rence of):						
cate be ex physician the buria	edic		d								
ath certifica attending p I for use as f	Ň L	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				_		23d	. Date of deli	verv
Attending Physician: The law requires that the death certificate be ar death.  ector: After this certificate has been signed by the attending physicit by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown			Ectopic pregnand Other (specify)	у			Month	Day Year
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To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director After this completed filled in by the funeral di	Medical	(Check 2 L Medical E	Physician: To the best of Examiner: On the basis of	examination	and/or invest	igation, in my opinio	n, death occurred	at the time, date a	nd place, and	due to the ca	ause(s) and manner stated.
To the within To the comple	Σ	only one) 3 Lx Certifying 29b. Signature and title of certifie	Nurse Practioner: To the	best of my	knowledge, o					d manner as s gned (Month,	
IZ		ruen	femmel	4C	RUF	> RI	5866		1/2	3/20	010
		30. Name and address of Serson		death (Item	, , , , ,	·	D DD 65	TI UED CO	DING	MD 2	000/
Stat	е	31. Date filed (Month, Day, Year)	2010 CRNP	ar's Signa	3160	RACEFIEL	υ кυ., S	LLVER SP	KING,	MD. 2	0904
Registra	r	NOV 09	2010 /	No 1	2 19	A STATE OF THE PARTY OF THE PAR					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 2010 Ye Physician/ Dorothy Elaine Goodwin <u>9:</u>54 <sup>A</sup>м November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Prince George's Fort Washington Health & Rehab Fort Washington Social Security Number If Under Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days (Month, Day, Director 578-52-3171 87 J<u>an</u> Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Fort Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 12021 Livingston Rd USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Important: If them 27 is marked other than "natul mortant: If item 27 is marked other than "natul any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 2 should be filed within 72 h ith and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Worker DC Public Schools Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) ပ Elsie Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennit Goodwin - Son 29578 Whalen Rd Charolotte Hall, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/30/10 Arlington National Arlington, VA 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Marcis 3401 Bladensburg Rd Brentwood, MD 23a art 1. Enter the closed e, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failury. List only one cause on tach line. Interval Ret Immediate Cause (Flhat Physician/ disease or condition Medical resulting in death) taminer Sequentially list conditions, Examine Due to (or as a cons if any, leading to immediate cause. Enter Underlying death certificate be executed and that initiated events resulting in death) Last physician a sthe burial-1 Physician/Medical Box 68760 attending philogolist at the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day 2 XNo ed by the a g Unknown g Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe or Attending Physician; The 2 🗌 No ☐ Yes 2 🔽 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita! 2 1 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ Nursing Home 5 Residence 6 Other (Specify) Juster death.

\*I Director: After th.

\*In by the fire. 27. May er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or A within 24 hours after To the Funeral Direc completed filled in by determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of ceptifie 29d, Date signed (Month, Day, Year) 111010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Laxmi N. Berwa, M.D.

31. Date filed (Month, Day, Year)

Clinton, MD

7700 Branch Ave.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 3:25 Gibson Vovember 12 2010 -0015e 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rimes Ame 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Months Hours 1 □ M 2 🕱 F 186-09-8376 96 October 22, 1914 maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1XYes 2□No Princess Anne Somerset Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21853 11974 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon osmetologist 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Handy Joshua Wilson Leah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona Hall - Neice Fentral Ave Salisbury, mg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Princess Anne, ml 11-70-10 4 Donation 5 Dother (Specify) Wesley Bowland Hill Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Ward F.H. ٤. 30639 Hampden Ave Princess Anne, md 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 pronths?
1 □ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

ģ

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination in the featurest.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Examiner physician and s the burial-tran use as attending properties for use as

Physician/Medical s been signed b à Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

the

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certificate I

IF FEMALE:

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No 3 Probably 4 thinknown 24a. Was an autopsy performed

1 ☐Yes 2 ☑No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

NATESAN

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1415 5 DIVISION Sheet

State Registrar

Medical

31. Date filed (Month, Day, Year)

Nith

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and M	lental Hyg	iene	0 7 5 7 7
				rtificate of Death	R	eg. No U	3/5//
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Deatl     Month	n Day Year	3. Time of Death
	Medic	al	Margaret E. Gerrity		Novembe	r 7, 2010	12:00 P M
j	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	
	Funeral		Heritage Harbor  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annapolis  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Aru	ndeL hplace (State or Foreign
	Director		344–18–8157 1 □ M 2 🔀 F 88 Yrs.	Months Days Hours Min.	reb. 26	Year) 1922 Pen	nsylvania
	- MC	Ė	Usual Residence of Decedent			7 11 = 2 011	
	yland f sho	ctor	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	e Mar r 28a notifi	Director	MD Prince George's Bowie	T			1 💆 Yes 2 □ No
	ith th	rall	12113 Millstream Dr.	10f. Zip Code 20715	1	0g. Citizen of What Co	untry?
	ath w	Funeral		Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	ioan Indian
٥	or its	by F	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ♣ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
9500-612	ırsaft ıral", IExa	edl	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2XXNo Specify:		Specify:	White
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ore.	of He of Herican		20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, crematery, cr	osition (Name of gratory or other place)	ate	20c. Location - City or	Town, State
aitimore,	Page ment tant: I		4 Donation 5 Other (Specify) Resurrect	tion Cemetery 11/12		Clinton,	
ga	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If the Z7 is marked other than "natural", or items Z3a or Z8a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 3		2. Name and Address of Facility		Funeral Ho	
_				5512 NW Crain Hwy.		e, MD 207	15
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7. 5.	that the the the the the the the the the th	by P	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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ם ב	ding th. After fune	cate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work?  M 1  Yes 2 No	8d. Describe hov	vinjury occurred	
TO HOISINIC	Atten r dea ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Stre	eet and Number or Rura	al Route Number,
≦ .	s afte		building, etc. (Specify)		City or Town,		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  Completed filled in by the funeral director, page 2 should be detached for use as the burial-transl completed filled in by the funeral director, page 2 should be detached for use as the burial-transl completed filled in by the funeral director, page 2 should be detached for use as the burial-transl completed filled in by the funeral director, page 2 should be detached for use as the burial-transl completed filled in by the funeral director, page 2 should be detached for use as the burial-transl completed filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death or not be provided by the companion of the death of the provided by the companion of the provided by the companion of the provided by the companion of the provided by the companion of the provided by the companion of the provided by the companion of the provided by the pro	occured at the time, date and place, and	I due to the cause	e(s) and manner as stat	ed.
;	the the function of the functi	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, a 29b. SignatOre and title of certifier	death occurred at the time, date and place 29c. License number	, and due to the o	ause(s) and manner as s	stated.
_ '	5.≱ <b>5</b> 8		230. Signable and the or orthogram	29C. Elcense number	29	ld. Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, J		- 1	1/2 08/30	
T	#1		Gan T Sprose 2168 DIE	Josep Drive	Chea le	1, WO 9/	619
3	Stat	е	31. Date filed (Month, Day, Year) NOV 1 0 2010 32. Fegistrar's Signature	- 41			
	Registra	r	INUY I U ZUIU   Brown B. D	are			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John James Hein. Sr. 8:58а м 2010 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Montgomery Rockville 8. Date of Birth (Month, Day, Year) 08/27/1918 . Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 1 X M 2 🗆 F Hours Pennsulvania Director 92 188-01-7090 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or 28a-f sl 1 Yes 2 X No Silver Spring Maryland Montgomery 5 10e. Street and Number 10g, Citizen of What Country? ms 23a or must be r Funeral 13011 Collingwood Terrace 20904 U.S.A. Iral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1941 - If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced "natural" 1945 Year or Dates Caucasian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than ' jury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Jonas Hein Elizabeth Coffee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Marie Beam - Daughter 13011 Collingwood Terrace, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Donation 5 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or Norbeck Memorial Pk. 11/12/2010 Olney, Maryland . Signatur 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave.. Silver Spring.MD 20904 23a. Part Conter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Hepatocellular Carcinoma Medical Due to (or as a consequence of) Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760

signed by the attending physician and doe detached for use as the burial-transit page 2 should within 24 hours after death.
To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inipury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)	23d. Date of delivery Month Day Year				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1  Yes 2 No 3						
		24a. Was an autopsy performed?  1  Yes 2 X No 2 4b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No				
25. Was case referred to medical	26. Place of Death (Check on	ly one)				
examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 12 Other (Specify) Hospice				
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) Injury work?  M 1 □ Yes 2 □ No	. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)				
20a Certifier 1 V Certifying Phys	sicians To the best of my knowledge, death accurred at the time, date and place, and d	ie to the causals) and manner as stated				

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Drive ; Bethesda,

D0063195

29d. Date signed (Month, Day, Year)

20817

November 06. 2010

29c. License number

State Registrar

Medical

29b. Signature and title of certifier

Steven D.

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilks,

Month, Day, Year)

6340

Rockledge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Ernest Wilton Henson 1:00a M 2010 Medical Nove mber 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number 8. Date of Birth (Month, Day, Yea 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Hours Min 579-46-9508 1 🙀 M 2 🗆 F 76 Yrs. Director Washington DC June 12. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/A Washington DC 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20009 United States 1831 Vernon Street, NW 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. **African** by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed American Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Printing Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 Wilton Ernest Henson Sarah Helen Proctor or other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is 1831 Vernon Street, NW, Washington DC 20009 Kaye D. Henson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 1 🖰 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 11/09/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. 20012 7400 Georgia Avenue, NW, Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician End-Stage Dementia disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sepsis with Lactic Acidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury Parkinson's Disease that initiated events resulting in death) Last attending physician and for use as the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execu-Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Benign Essential Hypertension, Type II Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy **Director:** After this certificate It in by the funeral director, page 2 X N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ျှ 1 Yes 1 - Inpatient 2 - ER/Outpatient 3 - DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar Nouro

NOV 09

Barbara

31. Date filed (Month, Day, Year)

D0065485

1500 Forest Glen Road, Silver Spring, Maryland 20910

01

2010

Ksu.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supanich, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended #24a per MD, RG FCHD 11/12/10 Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav November Da Year PAUL ALLEN HUTCHINS 0210 A M 6 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove montgomery Adventist HOSPita ockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Days Hours Min. 0472971946 196-36-3508 Director 64 PA Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MONTGOMERY MD POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19213 MUNGER FARM ROAD 20837 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 lih and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER SOFTWARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည other traumatic PAUL AMBROSE HUTCHINS MAMIE MANCUSO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20837 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau RUTH HUTCHINS / 19213 MUNGER FARM RD., POOLESVILLE, SPOUSE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. MARY'S CEMETERY 11/13/2010 BARNESVILLE, MD 20a. Methed of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S rvir e Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Death Brain inute Medical resulting in death) Due to (or as a consequence of): Examiner rdiac week Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Iweek Spiratory the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last by Physician/Medical week Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 4 | Pregnant | g | Unknown 1 Yes 2 9 Unknown 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Morbid Obes,+ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe after death.

Director: After this certificate Yes 2 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number M ARYLAND 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) aron N. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHULMAN 1495 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Ensua Registrar

0210

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/ Wallace Randolph HUFF Month Nov. 16 4:15 p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ct. 9,1920 1 📉 M 2 🗆 Months Hours Min Director 215-14-1680 90 Maryland Oct. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits Marvland Washington Clear Spring 1 Tes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 14710 National Pike 21722 TISA items ; 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces:

1 X Yes 2

If Yes, Give
Year or Dates. Black, White, etc. o þ 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: white Completed d 2 should be filed within 72 hours alth and Mental Hygiene.
127 is marked other than "natura or traumatic event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sheet metal aircraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic eve once. ပ William Huff Clara Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Huff - wife 14710 National Pike, Clear Spring, Md. 21722 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Lawn Mem. Park 11/19/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature Juneral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CIASTRO INTES disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ANEMIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit MOUTE and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Completed by Physician/Medical MYSOLIC te100511 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death Month Day Year 1 ☐ res ∠ ☐ g ☐ Unknown be detached Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPSIS 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed? Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 ▲ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death.

I Director: After the din by the funera 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 0006200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 4

31. Date filed (Month, Day, Year)

7HLO

ANTIGIAM

WIROW

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HATCHER JR. Month 4,2010 ROOSEVELT THEODORE 3:29 P M nuember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ፟ M 2 □ F Months Days Hours Min Director WASHINGTON, DC JAN 1946 64 <u>577-62-0886</u> Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director PRINCE GEORGE'S LANDOVER 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2205 MATTHEW HENSON AVENUE 20785 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status 1 Marmed Forces?
1 Marmed Forces?
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1 Marmed Forces?
1 Marmed Forces?
1 Marmed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 21215-0036 BLACK 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MEAT CUTTER PRIVATE permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th 11THBe Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ GLADYS JONES THEODORE R. HATCHER SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8702 GREENS LANE RANDALLSTOWN, MARYLAND 21133 GARY S. HATCHER/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 11/17/2010 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J.B.JENKINS FUNERAL HOME, INC. pature of Funeral Pervice Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the aid be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) မ 1 Inpatient ER/Outpatient 3 DOA Mannol of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year)  $5 \square$  Pending 1 Yes 2 🗌 No Investigation within 24 hours after deatl Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a, Certifier cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D64268 ress of person who completed cause of death (Item 23a) (Type, Print)

"CE BURNS 8/18 Good Luck Road Maryland 20706 8/18 Good Luck Road OXCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 2 2010 Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medic Examin				n, give street and nui	nber)			4h City	Town or	Location	of Death	Inoven	iber T			
	er	Baltimore Washington Medical Center   Glen Burnie   Anne Ar						Arun	del							
Funeral Director		5. Social Security No. 104–56–3	798	6. Sex 1 <b>XX</b> M 2 □ F	7. Ag	6 (In yrs. Ia 51	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of (Month) Aug.	Birth Day Yea 16,	1959	g. Birth New	nplace (State or Foreign ntry) Jersey
ihow at	٥٢	Usual Residence of 10a. State	10b. County	,		10c. City	, Town or Lo	cation								10d. Inside City Limits
faryla Ba-f s tified	Funeral Director	MD	Anne	Arundel		Crof	ton									1 ☐ Yes ŽŽŽ No
the h		10e. Street and Nun						10f. Zip	Code				10g.	. Citizen of \	What Cou	intry?
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 □ Never Marri 3 □ Widowed		If Voc Ci	orces?			Was Deced If Yes, spec 1 \( \subseteq \text{Yes}	ify Cubai	n, Mexica	n, Puerto	ecify Yes or Rican, etc.)	No-	Blac	e - Amer ck, White : Whi	
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ygiene /giene ner th			o.iday (0 12)	oonege (	2	,	L	oan C	ffic	er			E	Bankin	g	
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nd 2 sho ealth an m 27 is ner trau		Michell	e Rain	es—Handel	pou ong	se	2712	Verd	is L	ane,	er or Run	al Route Nui Croftc			114	Code)
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Depar Depar Impol any ir		21. Signature of Fur	peral Service	Elcel#866	>			2. Name an 6512				all Fu		I HOM	e 207	15
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Physician/		Immediate Cause ( disease or conditio	Final	only one cause on e			Cardi	ac	Do	th						Interval Between Onset and Death
Medical		resulting in death)	νn	a. Due to	lor on	0.0000000	once of:				^				$\dashv$	
Examiner	ı	Sequentially list co	nditions,	b. H	194	app.	nic OF	25/20	the	Ca	dia	24728	47	+		
sit 3d	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying	Due to	(or as	a consequ	ence of):									
e executed cian and urial-transit		that initiated events resulting in death) (	a conseque	ence of):								$\dashv$				
e be e ysiciar e burit	ical			<b>L</b> d												
tificate ng phy as th	Med	IF FEMALE:														
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death of the function of the Euhoratal Directors. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		Birth gnant a	of pregnar 2  Fetal It time of d	death 3	Ectopic p Other (sp		у				1	te of deli	very Day Year
requires that the de been signed by the should be detached	by PI	Part II. Other signif	icant condition	ons contributing to	death b	out not resu	ulting in the u	inderlying o	ause giv	en in Part	l.	23e. D	id tobacc	co use conti	ribute to	the cause of death?
quires en sig ould b	ted											1	☐ Yes	2 💢 No	3 🗆 Pro	obably 4 🗆 Unknown
has be	Completed											24a. V	Vas an utopsy			opsy findings available ompletion of cause of
The la	Con							_				1 🗆 Y	erformed es 2 <b>X</b>	?   No	death?	2 🗆 No
ician: certific ector,	Be	25. Was case referre examiner?	_	Hospital:							ath (Chec	k only one)				
Phys this ral dir	. To	1 Yes 2	<u>S</u> Wo	1 28a. Date	_		ER/Outpatier			4 L. N		ome 5	•			y)
nding Physician: T tth. : After this certifica e funeral director, p	cate	1 Natural 2 Accident	5 🗌 Pendii		nth, Da	y, Year)	injury	M	Bc. Injury work?			28d. Descri	be now ir	njury occurre	ed	
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Place		ury - At hor	me, farm, str	eet, factory	office				n (Street Town, St		er or Rura	il Route Number,
oital o urs af ral Di			D									,		,		
Hosp 24 ho Fune eted fi	Medical	(Check 2		g Physician: To the I Examiner: On the ba	sis of e	xamination	and/or invest	tigation, in r	ny opinio	n, death o	ccurred a	t the time, da	ate and pla	ace, and due	e to the c	ause(s) and manner state
Fo the within Fo the sompl	Σ	only one) 3 29b. Signature and		Nurse Practioner:	lo the	pest of my	knowledge,		License		e and plac	ce, and due t		se(s) and ma		
		▶ 3	-	South		N	D	7	220	000	44			17	8	P
11 14		30. Name and addre			- 1							130			1 1	2022
H-10.		31. Date filed (Month		DANNI CEC		352 ar's Signatu		16 F	orn	B1.	אר אר	130	Kock	5-1U	nu	22850
Stat Registra		o Date filed (World	INV 1 0	2010	-cyistl	ar s orgnatt	A A	nike	,							

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 8, 6:30AM 2010 November Joseph A. Handley, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Potomac Valley Nursing Home Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/10/1932 5. Social Security Number 7. Age (In vrs. last birthdav) 6. Sex **Funeral** Hours 1 💹 M 2 🗆 F Months Days Min 77 Director 578-42-3459 washington. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🛛 No Director Maryland Olney Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Brooke Meadow Lane 20832 U.S.A Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗶 No Specify: er than "natural", o Specify. 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Advisory Programmer Computer 7 is marked other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 'nent of Health and Mental Joseph A. Handley Helen Berger ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colorest and 2. Department of Health a Important; if Item 27 is any injury or other transonce. Kelly Conboy - Daughter 4813 Round Hill Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Pk 11/16/2010 | Clarksville, Maryland 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. art1. Enter the I sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stage Kidney Disease /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, the nding p use IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) o 9 Unknown signed by t be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? as 2 S autopsy performed certificate 1 □ Yes 1 ☐ Yes 2 ☐ No or Attending Physiclan; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 🗓 Nursing Home 5 🔲 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation n 24 hours after death.

le Funeral Director: A

oletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated To the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056345 November 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Piyush Patel, M.D., 12001 Ferrara Drive, Wheaton, Maryland 20906 31. Date filed (Month, Day, Year) State NOV 12 2010 Registrar

DHMH 17 Rev 1/2001

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Urooj Isfahani	

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State of Maryland / Department of Health and Mental Hygiene

rooj roidriani	1- For State Certificate of Death Registrar	Reg. No. 2010 3758
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year November 10, 2010  3. Time of Death 0000 hrs
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of D	eath 4c. County of Death
F	Howard General Hospital Columbia  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. [8. Date of Birth (MM/DD/YYYY] 9. Birthplace (State or Foreig
Funeral Director	219-98-1081   1   M 2   X   31   Yrs.   Months   Days   Hours	April 30,1979 Pakistan
w any	Usual Residence of Decedent  10a. State	10d. Inside City Limits
uth the Maryland 23a or 28a-f show any notified at once. al Director		10g. Citizen of What Country?
rith the N 23a or notified		United States  (Specify Yes or No- 14. Race - American Indian, Black,
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Wildowed 4 Divorced in res, Give year 1 Yes 2 No specify:	erto Rican, etc.)  Asian American  Specify:
5-0036 ed within 72 hourn lygiene. other than "naturn he Medical Exan Completed	Elementary/Secondary 20-12)  College (1-4 or 5+)  College (1-4 or 5+)  Technical Writer	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Najat Ali Istahani Nasree	ame (First, Middle, Maiden Surname) en Isfahani
MD 21 32 should th and Me 127 is ma umatic ev	Mustafa Ghulam Khawaja -husband   10412 Faulkher Ridg	or Rural Route Number, City or Town, State, Zip Code) ge Circle Columbia, MD 21044
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than 'injury or other traumatic event, the Medical To Be Complet	4 Donation /5 Other Specify	Date 20c. Location - City or Town, State Laurel, Maryland
Balt permit. Departr Import injury	21. Sign faire   Funeral Service   Censee   22. Name and Address of Facility   Donald V. Borgwe   4400 Powder M111	erdt Funeral Home, PA Road Beltsville, Maryland2070
Physician /Medical	23a Part I. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardifallure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries	ac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):	
Institution of the second of t	Ocquerition y not contations,	
ecuted and transit	events resulting in death) Last  Due to (or as a consequence of):  d.	
760, cate be execut physician and he burial - tra	UNPENDED AMENDED	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be exceuting within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfedical Certification: To Be Completed by Physician/Medical En		egnancy Month Day Year
ires that the dispense by the dispense by the detached by the detached by the detached by Physical by		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 V No 3 Probably 4 Unknown
Division of Vital Records, Ital or Attending Physician: The law requires its after death.  "I Director: After this certificate has been sighted in by the funeral director, page 2 should be errification: To Be Completed		24a. Was an autopsy prior to completion of cause of death?
of Vital Recoing Physician: The law After this certificate has been director, page 2 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 3 signeral director, page 4 signeral director, page 4 signeral director, page 4 signeral director, page 5 signeral di		1
of Vital ling Physician After this certifuneral director	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA	ursing Home 5 Residence 6 Other:
on of ending F ath. or: Afte he funer	128 Date of Injury 128h Lime of Injury 128c Injury at Work?	28d. Describe how injury occurred  Driver of auto involved in collision
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the funeral Certification:	Accident Investigation    Accident Investigation   28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 175 Eastbound , Columbia , Md
To the Hosp within 24 hos To the Fune completely fi		
8	and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d. Date signed (Month, Day, Year)  November 11, 2010
	30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/MFN#23bperMD11/16/10,BMW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 0 2010 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sprine Vontgomen If Under 1 Year auhill conter 7. Age (In yrs. last birthday, 9. Birthplace (State of Foreign Country) curity Number Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 10M 20F Yrs Director 577-56-7146 April 30,1943 D.C. 67 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a ( 20832 3727 Bel Pre Road Funeral United States deeth Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itema 11 Marital Status Unk. 1 X Yes 2 □ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 200 Married filmore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: African American þ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Picture Framer Art other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fit ment of Health and Mental H ant: if item 27 is marked oil Peach K. Jordan Laura Joy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18031 O'Hara Circle, Olney, Maryland 20832 Laura J. Brewer/mother or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial Z Cremation 3 Removal from State Depertment of important: if any injury or once. 4 □ Doration 5 □ Other (Specify) Chesapeake Crematrory 10/28/2010 Beltsville, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** o Mas horz /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of) Examiner Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physicien Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No.

9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the 6 t be detached f Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 DNo 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 1 Satural 2 Accident 5 Pending investigation Injury after deeth.

Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i Certifying Physician: To the hest of my knowledge, death occurred at the time date and place, and due to the manual(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

•	For State Registra
	1. Decedent's
	Verno

Physician
/Medica
Examine

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Madical Examirat must be rollified at abone.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-fransit Division of Vital Records, P.O. Box 68760,

Vernon Dean Kirkpatrick  Vernon Dean Kirkpatri	of Death
4a. Facility Name (If not institution, give street and number) Hillhaven Assited Ivg. Nursing & Rehab Ctr.  4b. City, Town, or Location of Death Adelphi  4c. County of Death Prince George	
Usual Residence of Decedent	s
	e or Fore
10a. State 10b. County 10c. City, Town or Location 10d. Inside	City Lim
Maryland Montgomery Silver Spring 1□Ye	es 2 🏋
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
1012 DeVere Drive   20903   United States	
Maryland Montgomery Silver Spring 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-
if Yes, Give 1 □ Yes 2 No Specify: Specify: White	
15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)   National Symphone	
Elementary/Secondary (0-12) College (1-4or 5+) Wasing in an analysis of the control of the contr	017
Musician National Symphor	.iy
10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10d. Inside   10d. Inside   10d. Inside   10d. Street and Number   10d. Street and Number   10d. Zip Code   20903   United States   10d. Country   10d. States   10d. Powder   10d. Zip Code   10d. City Code   10d. City Code   10d. Inside   10d. Insid	
19a. Informant's Name/Relationship (Type. Print)  Thomas R. Kirkpatrick -son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  8442 Sand Cherry Lane Laurel, Maryland 20723	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State	
1 Burial 2 Arcremation 3 Removal from State   Metropolitan Crematory 11/8/2010   Alexandria, Virginal Pace   Alexandria, Virginal Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Crematory 11/8/2010   Alexandria Pace   Metropolitan Cremator	inia
21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland	207
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approxim	nate
Immediate Cause (Final Change Deposition Company)	
disease or condition resulting in death)  End Stage Pancreatic Cancer  Due to (or as a consequence of):	
Sequentially list conditions	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Cause (Disease or injury that initiated events  C	
resulting in death) Last  Due to (or as a consequence of):	
Cause. Enter Underlying Cause (Disease or irjury) Hat Halder (Disease or irjury) Horith (Diseas	
d  IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months?  1   Very 2   No   4   Pregnant at time of death   5   Other (specify)   23d. Date of delivery   Month   Day	Year
1   Yes 2   No 9   Unknown 9   Unknown	
in the past 12 months? 1   Yes 2   No 9   Unknown	of death
1   Yes 2   No 3   Probably 4	Unkn
24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   2   2   2   2   2   2   2   2   2	ns avail
autopsy performed? death?	f cause
performed? death?  1   Yes 2   X   No   1   Yes 2   X   No    25. Was case referred to medical   26. Place of Death (Check only one)	
examiner?	
27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
1 Anatural 5 Pending (Month, Day, Year)   Injury   Work?	
3 Suicide 6 Could not be determined determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	umber,
building, etc. (Specity)  City or Town, State)	
29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Description of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	e(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,	)
D18895 November 8, 20	<b>1</b> 0
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mobarak Karim, M.D. 3311 Toledo Terrace, B-102 Hyattsville, Maryland 20782	
31. Date filed (Month, Day, Year)  32. Registrar's Signature	

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day lliam 2:44 AM 10 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death aseu House Kockville Hospice 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age In yrs. last birthday Min. **X** M 2 □ F Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No M D Chase Montgomery Chevy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4823 Leland Street 20815 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ederal Government Postal Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. Kirkland Doris A. Dammeyer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Kirkland/Niece Torrance Court, 19 Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven 1 Burial 2 Cremation 3 Removal from State Nov. 16, 4 Donation 5 Other (Specify) Silver Spring, MD 2010 Cemetery

500 University

22 Name and Address of Facility Collins Funeral Home Inc.

W

Interval Between

Onset and Death

Blvd.

Baltimore, Maryland 21215-0036

Default. Page 1 and 2 should be filed within 72 hours after detable bepartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine once.

Examine

Physician/Medical

Physician/

Medical

**Examiner** 

**Funeral** 

Director

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Funeral

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Completed

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Signature of Funeral Service Lice

Immediate Cause (Final

notified at Director

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Ph\_sician/ Medical Examiner

attending physician and for use as the burial-trans

signed by the a

within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

disease or condition resulting in death) Cerebral Thrombosis Due to (or as a consequence of) Cerebral Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of)

23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

ρ	Taren. Galer significant conditions	23e. Did tobacco use	e contribute to the cause of death?		
8				1 🗌 Yes 2 🗔	No 3 Probably 4 Unkno
Complete				24a. Was an autopsy performed? 1 □ Yes 2 ♣No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Be (	25. Was case referred to medical examiner?		26. Place of Death (Check	only one)	
Certificate: To E	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D0	OA Other: 4 \( \sum \) Nursing Hor	me 5 Residence 6 🗵	Hospice
	27. Manner of Death  **X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury o	occurred
Certi	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	y, office	28f. Location (Street and N City or Town, State)	Number or Rural Route Number,

7	71			
2	29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occure	ed at the time, date and place, and due to the	cause(s) and manner as stated.
١ ١	(Check	2 Medical Examiner: On the basis of examination and/or investigation	n, in my opinion, death occurred at the time, da	te and place, and due to the cause(s) and manner stat
	only one)	3 Certifying Nurse Practioner: To the best of my knowledge, death of	occurred at the time, date and place, and due to	the cause(s) and manner as stated.

	participation of the second pa	and thereofe) and machiner als ordinal
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Darbrah milter CENP	R143201	11/11/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hov

п		Miller,				Rockville	, MD
	31. Date filed (Mor	nth, Day, Year)	32 Aec	istrar's Signatua	1 1		

State Registrar

32 Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🔒 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November Da Physician/ 6:45pM Geraldine Paula Katz 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) Funeral Pennsylvania Days 1 🗆 M 2 🗶 F (Y2"1,28",1°1"927 83 209-12-0603 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State with the Maryland Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 🗌 Yes 2 🗓 No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20906 15107 Interlachen Drive, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Caucasian Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Home Typing Company Tupist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emilie Katz David Goldstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 704 Lamberton Drive, Silver Spring, MD 20902 Marc Katz - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 11/12/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Shon Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year been signed by the atte should be detached for Pregnant at time of death 11/10/10 1 ∐ Yes 2 μ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performed? 1 ☐ Yes 2 ☐ No 2 🗓 No 25. Was case referred to medica 26. Place of Death (Check only one) or Attending Physician: Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA Within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

only one

60

29b. Signature ar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D. Natasha Prtina Haag, 31. Date filed (Month, Day, Year,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician**  $P^{M}$ Kasunic Sr. J. Robert November 2010 7:05 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Gaithersburg Wilson Health Care Center If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number Funeral Months Days Hours 1 X M 2 □ F 163-24-4490 81 Sept. 26,1929 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Battimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exeminations in settle and itilied at Director Darnestown 1 ☐ Yes 2 X No MD Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20874 14409 Brookmead Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1X)Yes 2 \( \text{No Korea} \) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2🌠 No If Yes, Give Year or Dates Specify. Specify: þ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kasunic Helen Joyce ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14409 Brookmead Drive, Darnestown, MD 20874 Robert J. Kasunic Jr./ Son 20b. Place of Disposition (Name of cemeter), crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, VA 21. Signature of Funeral Ser 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, M01117 Gaithersburg, MD 20877 PACE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** phenwould weeks disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physician and or use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, The law requires that the death ce tificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the 1 ☐ Yes 2 ☐ No P.0. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗆 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To To the Hospital or Attending Physician Within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Man of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 7 2010 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Ave. Gzithersburg olinsk LUSSC teven 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		Otato or ini	y	Ce	rtificate of l	Death	,	Reg. No.	UIU	9/3	93	
			1. Decedent's Name (First, Mide	dle, Las	t)					2. Date of De	eath Day	Year	3. Time o		
	Physicia /Medic		Kaliope			K	Couts	andreas				010	3:15	P M	
	Examin		4a. Facility Name (If not instituti	ion, give	street and number)				Location of Death			County of Death			
		1	9930 Brixtone	Lan					hesda		Montgomery				
	Funeral Director		5. Social Security Number 579–36–6225	6. Se	ex 7. Ag □ M 2 🙀 F	e (In yrs. las 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D April	rth lay, <i>Year)</i> 8,192	9. Birth Con Wash	nplace (State untry) iington		
7	2		Usual Residence of Decedent			1-1							10d. Inside C	Situr Lilenito	
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4	s 23a	Funeral	9930 Brixtone	2 La		F	140	20817	lianonia Origin? /Pr	ancifu Vas or N		.S.A.	rican Indian		
ģ	item	n.	11. Marital Status		12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔯!		13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	o Rican, etc.)	0-	Black, White			
ر ا	l', or	by F	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce		If Yes, Give Year or Dates:	NO		1 □Yes 2 🛣 No	Specify:			Specify: Whi	te		
5-0036	atura		15. Decede	ent's Edi	ucation		16a. Dece	dent's Usual Occup	pation		16b. Kir	nd of Business/li	ndustry		
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ya Ya	Men arke	ျှ	Leon Norris						Mary Chi						
Mar	is m		19a. Informant's Name/Relation	, ,		1		ng Address (Street							
e, :	Healtl		Peter Koutsand	irea	s/Husband	20h Pla		D Brixton Osition (Name of	e Lane Be	Date		y Land cation - City or T	20817		
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Baltimor	rtmel rtant rigury	1	4 ☐ Donation 5 ☐ Other  21. Signature ☑ neral Sefficial					Cemetery  2. Name and Addre				kville,	Maryla	and	
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4			23a. Part 1. Enter the disease,	or comp	olications that caused	d the death.						0	Approxima Interval Be		
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	hysician /Medical		disease or condition resulting in death)		a. Lun Due to (or as	Canc							Month	S	
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X	oding p		iF FEMALE: 1 23b, Was decedent pregnant		23c. If yes, outcome	of pregnan	су					23d. Date of deli	iverv		
. go	n requires trat the death of been signed by the attendishould be detached for use	Physician/	in the past 12 months?		1 ☐ Live birth 4 ☐ Pregnant a			□ Ectopi <i>c</i> pregnand □ Other <i>(specify)</i> _	СУ			Month	Day	Year	
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ğ	en sig								-18	1 🔀	≹Yes 2[	□ No 3□ Pr	obably 4 🗆	] Unknown	
Vital Records,	as be	Completed								24a. Wa	s an opsy	24b. Were au	topsy findings	s available cause of	
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ב ב	And Triysclan. The law h. After this certificate has funeral director, page 2.8		27. Manner of Death 1 ☑ Natural 5 ☐ Pend		28a. Date of Inj (Month, Da	ury ay, Year)	28b. Time Injury	Wor		28d. Describe	e how injur	y occurred			
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Division	after of Direction by	Certification:	4 ☐ Homicide dete	rmined	building, e	tc. (Specify)	)	treet, factory, office		City or To	own, State	)	nai riodie iva	mber,	
_	ours ours eral filled		29a. Certifier 1⊠ Certif	ying Ph	ysician: To the best	t of my know	/ledge, dea	th occurred at the t	ime, date and plac	e, and due to th	ne cause(s	and manner a	s stated.		
3	to the hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medic one)	al Exan	niner: On the basis and manner s		on and/or	nvestigation, in my	opinion, death occi	urred at the time	e, date and	d place, and due	to the cause	(s)	
Ę	withii To the	M	29b. Signature and title of certi	ifier	1	~		29c. Licens	se number		29d. Da	te signed (Mont	h, Day, Year)		
	2		1.0	0			· .	MI	20177		roN	7. 8, 20	)10		
`	`		30. Name and address of person Nicholas G. Po	on who	completed cause of MD 4501	death (Item	23a) (Type	, Print)	ashington	, DC 20	8000				
	Sta	ate	31. Date filed (Month, Day, Yes		32/Regist	rar's Signat	re /	. d. 1					1 1 1 1 1		
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DHMH 17 Rev 1/2001

	•	For State Registrar		State of W	ai yiai			e of D		ivicinal 115	Reg. N	2010	37594
Physicia	ın/	1. Decedent's Nam Edwin	L. Ke	rr, Jr.		_			-	2. Date of Do	eath	<sup>2</sup> 2010	3. Time of Death
Medic Examin		4a. Facility Name (ii	f not institution, give	street and number)			4b. City	, Town, or	Location of Deatl	Nov.	3,	c. County of Deatl	10:30a <sup>M</sup>
/			Westbury						ille			Montgom	
Funeral Director		5. Social Security N	-1211	ex 7. Ag 7. Ag 8		last birthday) Yrs.	Months	r 1 Year Days	Hours Min.	8. Date of Bi (Month, D Mar 2	rth av, Year) 5 <b>, Î</b>	9. Birt Col N	hplace (State or Foreign Intry) Y
yland •f show ed at	ctor	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Loc	ation						10d. Inside City Limits
r 28a- notifi	Öİ	M D 10e. Street and Nur	Montgo	omery	F	Rockvi		p Code	<u> </u>		10- 0	Status and Addison Co.	1 Yes 2 No
with the same same same same same same same sam	Funeral Director		westbury	y Road			101.2	208	53		10g. c	Citizen of What Co	untry :
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Š		ried 2  Married	12. Was Decedent E Armed Forces? 1 X Yes 2	No	1		dent of His cify Cuban	panic Origin? (Sp., Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Amer Black, White	, etc.
ours a atural' cal Ex	eted	3 🔀 Widowed	4 Divorced  15. Decedent's E	If Yes, Give Year or Dates.	L946-4	16a. Deced					1 401	Specify: Whi	
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should and M is mai			ame/Relationship (T			19b. Mailin	g Addres	s (Street ar	nd Number or Ru	ral Route Numb	er, City o	or Town, State, Zip	Code) 20882
and 2 s Health em 27 ther tr		Edwin L  20a. Method of Disp		III/Son	Logi				r Crest		_	ithersb	
Page 1 anent of 8 ant: If its ury or of		1x Burial 2		Removal from State (y)	0	Place of Dispos cemetery, crem Car	atory or o	ther place	etery 1	Date 10 v 8 2010		Location - City or i	
permit. Departr Import. any inji		21. Signature of Fu	neral Service Licens	Myfurh_		22. 5 0	PPay O Ur	d Address					me Inc. Spring, MI
		shock, or hea	rt failure. List only o	plications that caused ne cause on each line	<b>).</b>	h. Do not ente	r the mod	le of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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th certific tending		IF FEMALE: 23b. Was decedent in the past 12	pregnant	23c. If yes, outcome 1 Live Birth	2 Feta	aldeath 3 🗌						23d. Date of deli	
the dear	Physician/	1  Yes 2 9 Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown	t time of o	death 5 🗆	Other (s <sub>i</sub>	pecify)				Month	Day Year
ires that signed b	by	Part II. Other signif	ficant conditions of	ontributing to death b	ut not res	sulting in the ur	nderlying	cause give	n in Part I.				the cause of death?
w requ	Completed									24a. Was			opsy findings available
The la	Com			-						auto perfe 1 🗆 Yes	ormed?	death?	ompletion of cause of 2  No
ician: certific rector,	Be	25. Was case referrence examiner?	_	Hospital:				Other	ce of Death (Chec				
g Phys er this eral dii	e: To	27. Manner of Deatl	_	28a. Date of injur	ry	ER/Outpatient 28b. Time of		OA   !8c. Injury :	4 ☐ Nursing H	ome 5 X Resi 28d. Describe		6 Other (Special of the Communication of the Commun	(y)
eath. or: Aft	Certificate:	1 <b>X</b> Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigation 6 ☐ Could not be		, rear)	injury	М	work?	es 2 🗆 No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		4  Homicide	determined	building, etc	. (Specify	")				City or Tov	vn, State	,	
ne Hosp in 24 hou ne Funei pleted fil	Medical	(Check 2	Medical Exami	sician: To the best of ner: On the basis of ex e Practioner: To the	kaminatior	n and/or investi	gation, in	my opinion	, death occurred a	at the time, date a	and plac	e, and due to the c	ause(s) and manner stated.
within Co.		29b. Signature and	title of certifier	)—			290	D62			29d. D.	ate signed <i>(Month</i> , v • 5 , 2	Day, Year) 010
20.			ess of person who o	ompleted cause of de	eath (Item	1 23a) (Type, Pr	int)	Cen	ter Dr	ive. R	ock	ville.	MD 20850
Stat		31. Date filed (Mont		32 Registra			Park.			,			

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 5, Day 2010 Physician/ Eileen L. 3:20 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner P.G. Renaissance Gardens at Riderwood Village Silver Spring 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Country D.C. Jan. 21, 1927 Min. Hours 577-38-4381 83 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🖁 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3110 Gracefield Road, Apt. CC-217 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married XX Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Uldowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be bearnit. Page 1 and 2 should be filed.
Department of Health and Mental Influencent: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John E. O'Brien Mildred England 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Kelly/Son 18720 Clover Hill Lane, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Nov. 12, Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2010 Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Cerebral Vascular Disease disease or condition resulting in death) unknown Medical Due to (or as a consequence of) Examiner unknown Diabetes Mellitus, Type II Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ing physician and e as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 X No Year Pregnant at time of death 1 Yes 2 I the detached g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Records, Cerebrovascular Accident, Advanced Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has death? certificate 1 ☐ Yes 2 ☐ No 2**X** No Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Tyes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1X Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of ce License number 29d. Date signed (Month, Day, Year) ۵ 158667 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State

Registrar

NOV 0 9 2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Evelyn Eloise Kinsey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western Maryland Health System Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. April 14, 1936 1 □ M 2 🕱 F 217-32-4381 Virginia 74 Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director West Mineral New Creek 1 Yes 2 No Virginia 10e. Street and Number 10g. Citizen of What Country? 106**276743** Funeral HC 75, Box 45-A United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify:White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Admissions Clerk 10 Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Jones Helen Atwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard G. Kinsey / Husband HC 75, Box 45-A, New Creek, WV 30743 20b. Place of Disposition (Name of Rescharge) crematory or other place)
Reschargen
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Nov. Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signatur of Frieral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, exe, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. 23a. Part 1. Enter the diser shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2. 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.s. autopsy performed Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 은 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbrook Rd, Lumberland, MDZISOZ 12500 hai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 10 Ida M Kauffman 2010 4:00 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Months Davs Hours Min May 21 1913 Director Pennsylvania 204-05-1765 Usual Residence of Decedent or items 23a or 28a-f show 10a, State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c City Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11208 Angus Way 21798 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 🛛 Widowed 4 🗌 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chain Weaver Manufacturing Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ John Elmer Feiser Maria Laura Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1aw Elayne Kauffman / Daughter-in-11208 Angus Way Woodsboro, Maryland 21798 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 16, 2010 York, Pennsylvania 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final NEUMONIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Examine Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ..... in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death the: signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? Yes 2-2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 24 hours after deatl Funeral Director: Suicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 the hin 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of MID 0061410

Registrar

DHMH 17 Rev 7/2009

State

HOUSE HY, FREDERICK, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 5:40 AM 2010 Jean M. Kayser 4a. Facility Name (If not institution, give street and number) Jean November, i /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Health Services Towson Baltimore 8. Date of Birth (Month, Day, Yes 04/18/1949 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 483-62-9955 61 Iowa Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene 1. Yis marked other than "natural", or items 23a or 28a-f show 17 marked other than "natural", or items be notified at raumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No Director PA Cumber land Camo Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 17011 3536 Countryside Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes XXNo Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Freckled Moose Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Fundraising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha C. Thilges Herbert J. Kayser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trat once, 26991 Southeastern Ave. Sioux Falls, SD 57108 William F. Kayser/Brother 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Evans Cremation Service 11/19/2010 Leola, PA 1 ☐ Burial 2 XI Cremation 3 XI Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ewing Brothers Funeral Home Inc. 21. Signature of Funeral Service Licensee m. tae Beach 630 S. Hanower St.; Carlisle, PA 17013 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CELL CARGNOMA SQUAMONS **Physician** DA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Be Completed pertension 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a, Was an certificate 1□ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 🗌 Yes 2 🗌 No investigation within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only

SH-15

State

one)

31. Date filed (Monta

29b. Signature and title of certifier

Registrar

29c. License number

8415 Bellona Lane #216, Towson

29d. Date signed (Month, Day, Year)

and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print)

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Naomi Simone	Kee		St	ate of	f Maryla	nd / Depa				Mental I	Hygiene		2013	01000	
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Physici	an/	Decedent's Nam	e (First, Midd	le,Last)			***				2. Date of D	eath		3. Time of Death	
Medical Exam		Naom	i Simo	ne K	eesee						Month Novemb	Day per 15.	2010 Year	0855 hrs	
		4a. Facility Name (				nber)		4b. City, T	own, or Loca	ation of Dea			c. County of De	ath	
		Prince Geo	rge's Hosp	ital Ce	nter			Chev	erly				Prince George's		
Funeral		5. Social Security I	Number	6. Sex		7. Age (In yrs.	ast hirthday)	If Linds	er 1 Year   If	f Under 24H	rs 8 Date of			Birthplace (State or	
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imore, MD 21215-00; Pages I and 2 should be filed within ment of Health and Mental Hygiene, fant: If tiem 27 is marked other the or other traumatic event, the Med	_	Danielle	N. Ke	esee	/Mothe	r	8608	3 Haml	in St.	.,Land	lover, Ma	aryla	and 20	785	
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t. Pa trent trant		4 Donation 5 Other Specify: Resurrection Cem. 11/26/10 Clinton,  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ington & Sons Co., In													
Baltimore, permit. Pages I an Department of Heal Important: If iten		100	11	21	- (	11	22	Henry	S. Wa	äsning	rton & S	Sons	Co., Ind	C.	
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BO) e death the att	Physi				9 Unknow	/n									
that the detached		Part II. Other signi	ficant condit	ons co	ntributing to	death but not re	esulting in the	underlying	cause given	in Part I.				to the cause of death?	
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Divisi  To the Hospital or Att within 24 hours after d  To the Funeral Direct	Medical			an	i the basis of d manner sta	examination ai	nd/or investig				at the time, dat		ice, and due to		
F > F 0	ž	29b Signature and	title of certifie	_		1		29c.	License num	nber		29d. [	Date signed (M	onth, Day, Year)	
		16/1	111	1 1	1	X	7		O.C.M.E.			Nov	ember 16, 2	2010	
	ŀ	30. Name and addr	ess of person	who com	pleted cause	of death (Item	23a)								
7		Zabiullah Al	i, M.D.	Assista	nt Medica	l Examiner	111 Pe	nn Street	, Baltimor	re, MD 2	1201				

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hyglene  Contributor of Doubt  Separation of Doubt  Contributor of Doubt  Separation of Separation  Separation of Doubt  Separation of Doubt  Separation of Doubt  Separation of Separation  Se				Plea							re All Copie			ble.	
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the model of lying, such as cardiac or rispiratory arrest, introduce council final process. Approximate introduced by the council final process. Approximate in	show d at	ř					10c. City	, Town or Lo	ocation					1	
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shock, or heart failure. List only one cause or each line.  Immediate Cause (Final Immediat	an July		Ka	18	1	-			16000 An	napoli	s Road Bo	wie,			
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The state of the s	he death certific y the attending p ched for use as	nysician/Me	23b. Was decedent in the past 12 r 1 Yes 2	months?	1 4	Live Birth Pregnant	2 Feta	Ideath 3		;y					*
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Tidewaker Colony Drive State  31. Date filed (Month, Day, Year)  32. Registrar's Signature,	ires that to signed by Id be deta		Part II. Other signifi	1 0	4 -	1 :	but not res	ulting in the	nderlying cause giv	ven in Part I.			•	1	_
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Tidewaker Colony Drive State  31. Date filed (Month, Day, Year)  32. Registrar's Signature,	ysiciai is certi directo		examiner?	<u>i</u>	Hospit	al: 1  lnpa	ient 2 🗆	ER/Outpatie	_ Oth	er \		sidence	6 Other	(Specify,	)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Tidewaker Colony Drive State  31. Date filed (Month, Day, Year)  32. Registrar's Signature,	or Attendate deatl	Certific	3 Suicide	6 Could	not be					res Z 🗆 N	28f. Location			or Rural	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Tidewaker Colony Drive State  31. Date filed (Month, Day, Year)  32. Registrar's Signature,	Hospital 4 hours Funeral I ted filled		(Check 2	Medical E	Examiner: Or	n the basis of	examinatior	and/or inves	stigation, in my oplnic	on, death occu	arred at the time, date	and plac	e, and due to	o the cau	use(s) and manner stated
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Tidewaker Colony Drive State  31. Date filed (Month, Day, Year)  32. Registrar's Signature,	No the within 2 to the comple	ž				ctioner: To the	e best of my	knowledge,			nd place, and due to t				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature,			16	9 (1	-HJ	510	4~)	MI		07-6	2693	- EU	21	0	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	H11H		30. Name and address			ted cause of	death (Item	23a) (Type,	Print) 2001 L 1 - A	. The	na bolis	CE	1004	311	
					3 2010	32. Regist	rar's Signat	ure d.	back	- / .1		-			

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene / U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ LESLYN 6:10am M NOVEMBER LYTE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death PRINCE GEORGE'S GEORGES CHEVERLY PRINCE GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Hours Min. 1 M 2 TF Director 065-82-2803 SEPT 10 1954 GHYANA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director PRINCE GEORGE'S HYATTSVILLE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6717 CENTRAL HILLS TERRACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. . Page 1 and 2 should be now...
...... If item 27 is marked other than "natural", or i' Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 5+<sup>College (1-4 or 5+)</sup> Elementary/Seconday (0-12) GOVERNMENT TEACHER æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ALBERT HAZEL ENID GEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 TERRENCE LYTE/HUSBAND 6717 CENTRAL HILLS TERRACE HYATTSVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 🗌 Burial 2 📉 Cremation 3 🗌 Removal from State injury or 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 11/13/2010 RIVERDALE, MARYLAND 21, Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Obstruction **Examiner** Intestina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of Ovanan Cancer attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 2 x No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Denpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on DOO 69796 ,20/0 person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 859 ≥zo<sup>Year</sup>() Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MANDRIN CHESAPEAKE HOSPICE HOUSE ANNAPOLIS, MD If Under 1 Year If Under 24 Hrs 6. Sex Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗖 Hours Min 12710/1929 Director GEORGIA 80 255-44-7006 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "netwer" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No ANNAPOLIS MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21401 USA 101 SPRING PLACE WAY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALMOND INGRAM ANNETTE DUNCAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>JANET I. BUTTS / DAUGHTER</u> 101 SPRING PLACE WAY ANNAPOLIS. MD 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 11/10/2010 STEVENSVILLE, MD 21. Signature of Tuneral Service Lice see EELLOWS ERAL CARE, P.A. off 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Sert 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) signed by the a d be detached f Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has page 2 s yes 2 No r this certificate baral director, page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After injury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: ,

completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier License numbe 118703 010 reverience Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Registrar's Signature

**08 201**0

145 DEFENSE HWY, ANNAPOLIS, H.D. 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Ralph S. Litton, Jr. 10:49A November Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Crofton Convalescent Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours 1 😿 M 2 🗆 F  $J_{\mathbf{u}\mathbf{l}\mathbf{v}}^{(Month, Day, Year)}$  17, 1935 Washington. 75 Director 579-48-9118 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland| Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? by Funeral 21035 USA 3283 Green Ash Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Clerk Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ralph S. Litton, Sr. Gladys Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis G. Litton/Wife 3283 Green Ash Road, Davidsonville, MD 21035 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Riverdale Bap. Ch.Cem.11/15/2010 | Largo, Maryland 5 Other (Specify) 4 Donati 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home Solomons Island Rd., Edgewater. trial caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complications shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequenticity list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Stage Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death the page 2 should be detached Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed ģ sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 2 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accider 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and

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DHMH 17 Rev 7/2009

State 31. Date filed (Month, Day, Year) NOV 0 9 20

ORIGINAL

completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ PM John William MARTIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 741 Summit Avenue 8. Date of Birth (Month, Day, Yes 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Months Days Hours Min. Country) Maryland 1924 Director 86 Sept. 219-14-9389 Usual Residence of Decedent 3a or 28a-f show be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a edical Examiner must be Funeral 741 Summit Avenue 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Was Decedent Ever III 0.5. Armed Forces?
1 ▼ Ves 2 □ No
If Yes, Give
Year or Dates. 1943–46 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced Completed 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Car Dealership Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rant: If item 27 is marked ot ည Ruth Elizabeth Mowen Livis Valentine Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Summit Avenue, Hagerstown, Maryland 21740 Betty J. Martin - Wife permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/16/10 Hagerstown, Maryland 4 Donation 5 Other (Specify) Rest Haven Cemetery . Signature of Faneral Service Lice 22. Name and Address of Facility Minnich Funeral Home 21740 415 E. Wilson Blvd. Hagerstown, Md. 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Poet and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or linium that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No P Month Day Year Pregnant at time of death ned by the a edetached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de þ Records, The law requires 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 UN 2  $\square$  No certificate Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DCA 5 Residence 6 Other (Specify) this eral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Certifying Nurse** 29d. Date signed (Month, Day, Year) 29h. Sic ature License numbe 704 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per

State

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Registrar

31. Date filed (Month, Da

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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 06, Physician/ 2:16aM 2010 Egbert Joseph Morgan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) 01/26/1929 1 🛛 M 2 🗆 F Months Days Hours Min. Country) Ja<u>maica</u> **Director** 579-96-8586 81 Usual Residence of Decedent Garnit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Silver Spring Maruland Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral U.S.A. 2106 Coleridge Drive 20910 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Porter Commodore Management Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Clara Bell Robert Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2106 Coleridge Drive, Silver Spring. MD 20910 Eunice R. Morgan - Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 11/13/2010 | Rockville, Maryland Parklawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mo #1070 11800 New Hampshire Ave., Silver Spring. MD 20904 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disc Approximate List only one cause on each line shock, or hea Onset and Death Immediate Cause (Final Ph\_sician/ Hupotension disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Bowel Obstruction Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death n signed by the a Id be detached f Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown Records, Coffee Ground Emesis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cirrhosis autopsy has After this certificate har funeral director, page performed 1 🗌 Yes 2 🗌 No Cardiomyopathy Yes 2 X No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗶 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) |2 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I To the only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

N.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Registrar's Signa

Smitha Bhikkaji, 31. Date filed (Month, Day, Year)

NOV 1 0 2010

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1500 Forest Glen Road, Silver Spring, Maryland 20910

November 07. 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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$\sim$	permit Depar Impor any in		1 leves	nced:	Myfugh	-	F	Name and Addre rancis J. ( O Universi	ollins Fur ty Blvd. V	eral Home ., Silver	Inc. Spr	ing, MD	2090	1
十	Physician/	. 1	shock, or heal Immediate Cause (		one cause on each	line.	n. Do not ente	er the mode of dyir	ig, such as cardiad	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)		a. Kidney C	ancer as a consequ	ence of):							5 yrs
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72	cate be executed physician and sthe burial-transit	al Ex	resulting in death) I		Due to (or a	as a consequ	ence of):			•				
09/	cate by physic s the b	ledical			d									
Box 68	tth certifi ittending or use a	≥	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐	months?	23c. If yes, outcor 1  Live Birt 4  Pregnan 9  Unknow	h 2 🗌 Fetal It at time of d	death 3	Ectopic pregnand Other (specify)	су			23d. Date Mon		ery Day Year
O.	ires that the dea signed by the a Id be detached f		9 ☐ Unknown Part II. Other signif				ultina in the u	nderlying cause giv	ven in Part I	230 Did t	obsess	una contrib	outo to the	e cause of death?
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₩.	Physic this coral dire	<u>و</u>	1 Yes 2 2. 27. Manner of Death			atient 2 🗆 I			4 ☐ Nursing F	lome 5 🗆 Resid				
	ending   eath. or: After he funer	Certificate:	1 X Natural 2 ☐ Accident	5 Pending Investigation	n	Day, Year)	28b. Time of injury	28c. Injun work M 1 🗆		28d. Describe h	now inju	ry occurred	1	
} ≤ d C ( Division	声	al Certi	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could not b determined	28e. Place of I	njury - At hor etc. <i>(</i> S <i>pecify)</i>	ne, farm, stre	eet, factory, office		28f. Location (S City or Tox	Street ar vn, State	nd Number e)	or Rural I	Route Number,
MA	the Hospi in 24 hou the Funet ipleted fill	Medical	(Check 2	Certifying Phys.   Medical Exams Certifying Nurs	iner: On the basis o	f examination	and/or invest	igation, in my opinic	n, death occurred :	at the time date a	and place	e and due t	o the caus	eale) and manner stated
	Mith o P of the		29b. Signature and t	title of certifier	(6)	MI		29c. License	16/6		29d. Da	ate signed (	Month, D	**
			30. Name and addre		completed cause of 5454 Wiscon				MD 20815					
	Stat Registra	_	31. Date filed (Month	h, Day, Year) V 09 201	2. Regis	etrar's Signatu	ire Acces	C.S.						

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November

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Andrew

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year 2010 <u>Edwin Bruce Miller, Jr.</u> 16. /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Washington Homewood at Williamsport 1 Year | If Under 24 Hrs. | 8. Date of Birth
Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F Months Days Yrs Director 578-48-6977 Oct. 26, 1938 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shore Director 1 XYes 2 □ No WV Berklev Martinsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Constable Lane USA Funeral 25401 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ages 1 and 2 should be filed within ont of Health and Mental Hygiene. It: If item 27 is marked other than "y or other traumatic event, If a Mental and a should be sho Elementary/Secondary (0-12) College (1-4or 5+) +6 Business Owner Tool & Die Machinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Edwin Bruce Miller, Sr Frances Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lillian C. Miller</u> / Wife 104 Constable Lane, Martinsburg, WV, 25401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/18/2010 Smithsburg, MD Smithsburg Crematorium 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home  $\mathcal{L}_{\mathcal{L}_{\mathcal{I}}}$ 305 North Potomac St., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one call se on each line. e mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GR disease or condition resulting in death) /Medical Dow to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (lisease of kind) that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f Parvi. Other significant or ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 □Yes 2 🗌 No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, e Funeral I within 2

Maryland 21215-0036

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H18+1 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

certifie

29a. Certifier

29b. Signal

(Check only one)

Medical

29d. Date signed (Month, Day, Year)

0/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lois Malott Marv 11:06 A M 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Loyalton of Hagerstown Hagerstown Washington Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2**X**□ F Days Hours Min. 1928 Pennsylvania Director 212-24-3076 82 September 6, Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 14402 Barkdoll Road 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington County Elementary/Seconday (0-12) College (1-4 or 5+) Schools Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George E. Reecher Elenora McKenrick 19a. Informant's Name/Relationship (Type, Print)
Robert Malott (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1442 Barkdol Road, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/16/2010 1 Burial 2 X Cremation 3 X Removal from State Shippensburg, 4 Donation 5 Other (Specify) Dugan Funeral Home & Crematory, Inc. Pennsylvania 21. Signative of Huneral Service License Paul T. Lochstang for 22. Name and Address of Facility
Locustampion Funeral Home, Inc. 48 S. Church St., Waynesboro, Pennsylvania 17268 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on partitipe. Interval Between Immediate Cause (Final Onset and Death Physician ementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Lisease or illijury Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death To the Funeral Director, completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO050362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cantone 13424 agerstown MD 21742 aistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mario A. Martin 9:40 A M 2010 Medical Nov 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2201 Arctic Fox Drive Prince George's Mitchellville **Funeral**  Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, an 30 218-04-1980 1 XM 2 F Days Hours Director 42 1968 Washington, DC Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In ment of Health and Mental Hygiene. In anti-I file as 23a or 28a-f sho lanti. If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's Mitchellville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2201 Arctic Fox Drive 20721 IISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify: 3 X Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Plummer Spartan Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Jackson Marva King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marva Jackson - Mother 2201 Arctic Fox Dr. Mitchellville, Md. 20721 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of H
Important; If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 11/15/10 Brentwood, MD 21. Signature of Funeral Service Icensee 22. Name and Address of Facility Fort Lincoln Funeral Home reta Typaxcis 3401 Bladensburg Rd Brentwood, MD 23a. Part 1. Enter the disselfe, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail re/List only one cause on each line. Interval Between Immediate Cause (Fin I Physicians Onset and Death Multiple Sclerosis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or imjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day signed by the at Id be detached for Pregnant at time of death Month 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' After this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 🔀 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending injury ☐ Accident 1 Tes 2 🗌 No Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058290 11/10/10

State Registrar 5711 Sarvis Avenue, Suite 200

Riverdale, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh K. Muttath,

NOV 1 2 2010

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 Physician/ MARIA MCMILLAN -COLLINS NOVEMBER FRANCES 2010 11:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) SEPT 26 1 □ M 2 🔯 F Months Hours 215-28-5632 Director Yrs CALIFORNIA  $^{\prime}1918$ Usual Residence of Decedent 28a-f shov 10a. State event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No UPPER MARLBORO PRINCE GEORGE'S MD ٥ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 23a Funeral 20772 9313 MIDLAND TURN items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 14. Race - American Indian. Black, White, etc. 9 þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 🔀 Yes 2 □ No Specify: PUERTO RICAN "natural" 3 Widowed 4 Divorced Completed Specify: AFRICAN AMERICAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT POSTAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ JAMES MCMILLAN RODRIGUEZ CLADYS Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code if Health 9313 MIDLAND TURN UPPER MARLBORO, MARYLAND 20772 JANICE COLLINS/DGT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o ₽ cemetery, crematory or other place 1 NBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 11/12/2010 SUITLAND, MARYLAND Gignature of Fineral Service Licensee J.B.JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, CARDIAC ARREST disease or condition Medical resulting in death) Due to (or as a consequence of Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events RAPID ATRIAL FIBRILLATION and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical DEMENTIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 Xivo Month Day Pregnant at time of death Year the Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed certificate 2 🔀 No Yes 2 XNo 1 Tyes 25. Was case referred to medical director, Be B 26. Place of Death (Check only one) Hospital 1 🔲 Yes 2 🛚 No Other 읻 this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 NOVEMBER 6, 2010 D41752 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 BERGIT **SCHOELLMANN** 31. Date filed (Month, Day, Year) NOV 1 2 2010 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3761 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RUTH WILSON MADDRIX 2010 November 6:10 A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Center Towson Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Months Days Hours 215-12-6328 87 **Director** Yrs 1471771922 Maryland Usual Residence of Decedent show death with the Maryland at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified Maryland 28a-f Howard Columbia 1 X Yes 2 No ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11118 Cricket Hollow Court 21044 U.S.A. items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced White Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jack Wilson Margaret Bain and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important; If item 27 is Carole Windsor (Daughter) 11118 Cricket Hollow Court - Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunnyridge Memorial Park 11/12/2010 Crisfield, MD Mary Beth Bradshaw-Pruitt 22. Name and Address of Facilify Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ Onset and Death Bladde CONCE disease or condition ) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Duc to for as a consequence of if any, leading to immediate cause. Enter Underlying the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ō in the past 12 months? Pregnant at time of death Month Day be detached the 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? ☐ Yes 2 No this certificate 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Hospital Certificate: To 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA migue To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 1 Tes 2 🗌 No 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XT5 State

Registrar

FARON

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Κ. 1925 Harnam Matta Novembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist HOSPITA montaoner 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Months Director 230-13-0905 90 India Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18700 Capella Lane 20877 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Completed by 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: Asian 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Karamchand Ahauja Hero Ahauja 19a. Informant's Name/Relationship (Type, Print) Matta, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jogender Singh Matta- SON 18700 Capella Lane, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt Wash Crematory 11/5/2010 Laurel, Maryland 21. Signature of Furnal Service Licensee <sup>22</sup> Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Mo/23 Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (hysician) perca pneic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner monar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 L. retai acc 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Day been signed by the a should be detached to g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ĀNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director; After this certificate I 2 1 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 🗀 Yes pital:
1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of injury
injury
28c. 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No. Accident
Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Rockville Brian benter MD medica 9901 20850 31 Date filed (Month, Day State NOV 082010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ELIZABETH o 3 MASON 2010 17:46 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL COULMBLA HOSD ITAL HOWARD 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 23734 Months Days Hours (Month, Day, Year) July 5, 1921 218-16-3330 89 Director Yrs Maryland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland Howard Columbia 1 🗆 Yes 🏖 No 10e, Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? by Funeral 4994 Beaver Brook Road 21044 U.S.A. ral", or items 2 Examiner mus 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White Completed 3 Divorced 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Accountant 12 U.S. Government Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Majden Surname) 2 Walter L. Brady Catherine A. Riordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Mason/son 9639 Cold Star Court Columbia, Maryland 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 11/8/2010 |Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 00 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death ATHEROSCIEROIL CORONAR disease or condition ARTER 5445 Medical resulting in death) Examiner Due to (or as a consequence of) DIFFICUE COUTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last CLOSTRIDIUM Due to (or as a consequence of): Exami ttending physician and or use as the burial-tran Due to (or as a consequence of) Physician/Medical de th certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month Day Year by the g Unknown Unknown or Attending Physician: The law requires that the P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s performed? Yes 2X No 1 Yes 2 🗶 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 💢 No Other: 1 🗌 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of After 28d. Describe how injury occurred 1 X Natural 5 Pending iniury e Funeral Director: Aft oleted filled in by the fun Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопрые (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN (MEDICAL DOGGE) 050404 NOV. 04, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Alkesh Patel LITTLE PKWY PATUKENT Counsu, SMUTE 11( 21044 31. Date filed (Month, Day, Year) State NOV 082010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 Physician/ 2010 November 0250 <u> William O. Murray Sr</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 1428 Regent St. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Days Hours 86 Maryland 219-12-3100 1923 Director Dec Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 1428 Regent St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. City of Annapolis life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the longe. Public Works 4th Carpenter æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Murray Mary Ida Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia C. Allen(Daughter) 5215 Disney Ave Baltimore, Md. 21225 20a. Method of Disposition 20b. Best Deposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State Memorial Park 11-9-10 Annapolis, Md. 4 Donation 5 Other (Specify) Wmame Rasseof Acim Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence f) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death by the ate has been signed by the page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗹 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 ☐ Yes 2 ☐ No ☐ Yes 2 ours after death.

eral Director, After this certific filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: (2 Other 2 460 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 27, Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 🗆 Pendin**g** 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after Funeral Direc determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and bit 112009 09 on who completed cause of death (Item 23a) (Type, Print) 1104 orb ady au) 31. Date filed (Month, istraris Signature State

Registrar

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	1	For State Registrar	State of	Maryland / De <i>C</i>	partment of ertificate of		and Mental Hy	giene 0 1 0	37617
		1. Decedent's Name (First, Middle,					2. Date of De	eath Day Octysa	3. Time of Death
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Examine	r	4a. Facility Name (If not institution,		er)	4b. City, Town,			4c. County of De	
		Holy Cross Hosp: 5. Social Security Number	<u>ital</u> 6. Sex 7.	Age (In yrs. last birthda	Silver		24 Hrs. 8. Date of Bi	Montgome	ery Sirthplace <i>(State or Foreign</i>
Funeral Director		None	4 🗆 M 2 107 E	O Yrs	Months   Dave	s Hours	Min. (Month, D.	ay, Year)   (	Country)
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with the	<b>a</b>	10e. Street and Number			10f. Zip Code			USA	Country :
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BAITIMORE, INIATYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item ZI is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinatinals to nother and once.	၉	19a. Informant's Name/Relationsh	nip (Type. Print)	19b. M	ailing Address (Stre	et and Numb	er or Rural Route Numi	ber, City or Town, State	a, Zip Code)
MC and 2 standard and 2 standard and 27 is ir trau		Seth M. Meacham	/Father	1230	5 Flaming	go Lane	e, Bowie, M	ID 20715	
Salfimore, bermit. Pages 1 ar Department of Her mportant: If item any Injury or othe		20a. Method of Disposition		20b. Place of Di	sposition (Name of rematory or other p		Date	20c. Location - City	or Town, State
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Balt permit. Departi Imports any Inji once.		21. Signature of Funeral Service I	icensee				y George P.		
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BOX eath cerraterdin for use	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live bit	ome of pregnancy th 2  Fetal death ant at time of death	3 ☐ Ectopic pregna 5 ☐ Other (specify)			23d. Date of Month	Day Year
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Attending r death. sctor: After	icat	2 Accident investig 3 Suicide 6 Could r	not be	f Injury - At home, farm		□Yes 2□		(Street and Number or	Rural Boute Number.
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				est of my knowledge, o					
ne Ho 1 24 h ne Fui	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	sis of examination and/er stated.	or investigation, in m	y opinion, de	eath occurred at the time	e, date and place, and	que to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signed (M	onth, Day, Year)
		aua	500 OD 130	e.b.	D555	15		11/02/2010	<u> </u>
2 1) 1	į	30. Name and address of person					· MD 000	110	
(144)		Andrea Lotze, M				er Spr	ing, MD 209	3.T.O.	
Stat Registra		31. Date filed (Month, Day, Year)	9 2010 2	Revers Signature 6.	back				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar MEND#24aperMD, 11/10/10, BW, McCo Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month Ralph <sup>Day</sup> 010 Nigro Nov. 4 , 9:05p M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
C T 8. Date of Birth Month, Day, 1 **X** M 2  $\square$  F Days Months Hours Director 045-12-7362 87 Nov. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MD 1 Yes 2 No Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12212 Cedar Hill Drive 20904 USA and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural". or Hems 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 🔀 Yes 2 □ No If Yes, Give Year or Dates. 1 Baltimore, Maryland 21215-0036 1 ☐ Yes 🕏 🔀 No Specify: Completed 3 Divorced 4 Divorced White Specify: 1942-46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Nigro Antonette George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 9 0 4 Nancy Ellen Nigro/Wife 12212 Cedar Hill Dr., Silver Spring, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ott Date 5 , 20 1 0 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Nov. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licenses Francis J Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrorasevar Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dise to for each process were even Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran-Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMAL € nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? or Pregnant at time of death signed by the at I be detached fo Month Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperlipidemia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Hearing Impairment 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 1 Yes 2 X No director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at work? 28d. Describe how injury occurred ospital o. 24 hours after deau... ral Director: After injury 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Destroying Physician to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

To the [ 10+

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

10

Registrar DHMH 17 Rev 7/2009

State

MD

70

ause of death (Item 23a) (Type, Print)

ke writ Z

lur

29c. License number

D31001

Greenbelf, MID.

7500 Greenway Cate. Dr.

29d. Date signed (Month, Day, Year)

11/5/2010

Physicia Medic Examin Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit Division of Vital Records, P.O. Box 68760

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hysician/ Medical	ı	Hoanh	C.			Nguyen						Month Nov. 6,		0ay . <b>0</b>	Year	3:00 a M
Examiner	2	la. Facility Name (if	not institution	n, give str	eet and numi	ber)		4b. C	ity, Town, c	r Location	of Death			c. County	of Death	
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uneral rector	L	5. Social Security N 220–37–226	54	6. Sex 1 🕱	M 2 □ F	7. Age <i>(In yr</i> s. <b>86</b>	V	" Month	ns Days	If Unde Hours		8. Date of Bi (Month, Da Nov. 22	rth ay, Yea <i>r</i> 192	23 _	9. Birth Cour	place (State or Foreign htry) <b>Vietnam</b>
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Examine Examine		1 Never Marr			Armed Ford 1 Yes If Yes, Give Year or Dat	2 🔀 No		If Yes, s		n, Mexica	in, Puèrto F			Blac	k, White, <b>Asiar</b>	etc.
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rked o	ľ	17. Father's Name (First, Middle, Last)  Cong Nguyen  18. Mother's Name (First, Middle, Maiden Surname)  Do Unknown											<i>t)</i>			
n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 13122 Venetian Road, Silver Spring, MD 20904										tate, Zip (	Code)			
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	2	20a. Method of Disposition  1  Burial 2 Cormation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metropolitan Crematory  20c. Location - City  Alexandria,														
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completed filled in by the funeral director, page 2 should be detached for use as  Medical Certificate: To Be Completed by Physician/Me		IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1   Live Birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of outcome of pregnancy   2											ery Day Year			
by PI	F	Part II. Other signif	icant conditi	ons contr	ibuting to dea	ath but not re	sulting in th	e underlyin	g cause giv	en in Part	l.	23e. Did t	obacco	use contri	bute to th	ne cause of death?
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d in by th		3 ☐ Suicide 4 ☐ Homicide	6 🔲 Could determ			of Injury - At ho g, etc. (Specif		street, facto	ory, office		2	8f. Location (8 City or Tou			r or Rural	Route Number,
pleted filled	2	(Check 2	Medical E	xaminer	: On the basis	st of my know of examination the best of m	on and/or inv	estigation, i	in my opinic	n, death o	ccurred at the	he time, date a	and plac	e, and due	to the car	use(s) and manner state:
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0800 cm Osborne 4 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NM5 or Hacerstown Hagerstown Washington 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov . 2, 1934 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 ☐ M 💥 F 76 233-50-9376 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the M. dical Examiner must be notified at 1 ☐ Yes 2 No Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 14014 Marsh Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ½ Yes 2 □ No 1964-If Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: þ ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Grace Hutton UNK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 is other tra Virginia Beach, Virginia 23451 Beverly L. Thorpe-Daughter 426 Pinewood Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 Burial 2 Cremation 3. □ Removal from State Enders & Shirley Crematory Nov.16,2010 Berryville, Virginia 4 □ Donation 5 □ Of ignature of F OSBOTTE TUTELT ALIVHOME, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 140 ena /Medical Due to (or as a consequence of) Examiner nconic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 🗌 No 3

☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2/No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely To the P within 24 To the F and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Hagerstown 14014 Marsh Hagerstown Degistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3762 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 0 1 0 Douglas William O'Keefe. Jr. 1:25 a.M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Sanctuary at Holy Cross Burtonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number Funeral Maryland 1 🕱 M 2 □ F Months Days Hours Min (Month, Day, Year) 09/19/1941 Director 213-42-6736 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Tes 2 X No Silver Spring Maruland Montaomeru 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20905 2108 Steuben Way 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗆 No 1964—
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced 1965 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PEPCO 12 Lineman/Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Douglas William O'Keefe, Sr. Sarah Goune Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring. Maryland 20905 Nancy S. O'Keeke - Spouse 2108 Steuben Way. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State [11/15/2010 | Burtonsville, MD 4 Donation 5 Q Other (Specify) Union Cemeteru Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 1100009 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani Advanced Melanoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 L Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 X No ours after death. eral Director; After this certific filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar

4+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunitha Bhogavilli.

31. Date filed (Month, Day, Year)

M.D.,

D0054566

9801 Georgia Avenue, #1-17, Silver Spring, Maryland20902

November 10. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Benjamin Lee Overton 4:26 2010 November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glenn Dale Prince George's 12212 Sir Lancelot Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex Days 1 🛛 M 2 🗆 F Washington, 72 578-48-9398 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Glenn Dale 1 X Yes 2 No Prince George's Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 12212 Sir Lancelot Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married X Yes 2 No 1 Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced KOREAN Year or Dates. 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) US Postal Service Postal Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edith Goldsmith William Overton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine D. Overton / Wife 12212 Sir Lancelot Drive, Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 11/12/2010 Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of) Coronary Artery Disease Due to (or as a consequence of) Atherosclerosis Due to (or as a consequence of) yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy

Physician/ Medical Examiner Examine

burial-transit

as attending for use as Physician/Medical

<u>\$</u>

Completed

Be

Certificate:

physician s the burial

signed by the a d be detached f

page

certificate

After this funeral d

within 24 hours after death.

To the Funeral Director: Af

that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

Physician:

or Attending

Hospital

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Physician/

Medical

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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ge 1 and 2 s it of Health a If item 27 i

traumatic

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Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 2 🔀 No

performed? 2 🔀 No 26. Place of Death (Check only one)

1 🗌 Yes

4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify)

11/10/2010

1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred injury X Natural 5 Pendina

Accident Investigation 6 Could not be 4 Homicide determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

D25802

28f. Location (Street and Number or Rural Route Number.

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4700 Berwyn House Road, Suite #104, College Park, MD 20740 Amjad M. Rasul,

State Registrar

31. Date filed (Month, Day, Year) 2010



Maryland 21215-0036 Box 68760 P.O. Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ T3, 2016 George Akerman PLANE November 1=04 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4129 Mills Road Sharpsburg Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🔀 M 2 🗆 F  $\operatorname{April}^{(Month, Day_3^{Year)}}1930$ New York 100-24-1041 80 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Washington Sharpsburg 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4129 Mills Road 21782 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 

Yes 2 □ No
If Yes, Give white 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) automotive mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ralph Scovel Plane Fairy Mae Akerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Ann H. Plane - wife 4129 Mills Road, Sharpsburg, Maryland 21782 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, 1 Burial 2 Novement Cremation 3 Removal from State Hagerstown Crematory 11/15/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland . Signature or Funeral Service Licer 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death arkinson's Physician/ disease or condition years Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown emensia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifig 11/15/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H 5+1 610 9th AVE, BRUNSWICK, MD 21716 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- Description   Medical   Maria   Price				Ctota	oartment of Health and I ertificate of Death		ene g. No.2 0 1 0	37624
Part   Part		Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death		
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Disclarate Haselines of Benefits of Secretary 150 Secretar	-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.		0.8:4	lace (State or Foreign
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Special Continues   Spec	ა ზ	and 2: lealth em 27 her tr			6 Connemara Dri	ve, Ste	rling, VA	20164
Solid University Blvd. W., Silver Spring, M.	J01	ige 1 and int of H		1 🖾 Burial 2 🗆 Cremation 3 🔲 Removal from State	ematory or other place)	Nov 15	c. Location - City or To	vn, State
Special Continues   Spec	탩	it. Pa artmer ortant injury			ncoin Cemetery	2010		
Approximate flativistic leases, or complications that cauded the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shocks or forest failure. List only one cause or machine.  The mediate Cause (Final Final a	Det Timp	9	And the strice licensee	Franciscustration 11	ins Fun	eral Home	Inc.	
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State 31. Date filed (Month, Day, Year) 82. Registrar's Signature Registrar				30. Name and address of person who completed cause of death (Item 23a) (Type, Richard J. Feldman, MD 8116	Print) Good Luck Rd.,	Laham,	MD 20706	
				31. Date filed (Month, Day, Year) 22. Registrar's Signature	W			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lilly Padgug ovembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore ta Ltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth
(Month, Day, Year)
July 15, 1925 **Funeral** 1 M 2 X F Director 112-16-0260 85 Usual Residence of Decedent permit. Page 1 and 2 should e filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is mar ed other than "natural", or items 23a or 28a-f show any injury or other traumatir event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director Frederick Maruland Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 200 East 16th Street 21701 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Law Office 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Sacharoff Ethel Rothenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Palmspring Drive, Gaithersburg, Maryland 20878 Steven Lawrence Padgug - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns: 11/08/2010 Olney, Maryland 21. Signature of Tuneral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onsetland Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner or as a consequence of): e attending physician and ed for use as the burial- ansit LSYStem To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year been signed by the a should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying c*a*use given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been irector, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mapner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No \*Accident Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 140701856-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOTZ, MA 31. Date filed (Month, Day, Year) State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 37626 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 1, 2010 Hazel B. Plunkett 7:15am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Sligo Creek Nursing Home Takoma Park Montgomery 8. Date of Birth (Month, Day, **Dec.** 9, **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 X Months Days Hours Director 577-50-7757 Washington, DC 74 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified DC Washington 1 X Yes 2 ☐ No 5 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 23a Funeral 776 Girard Street, N.W. 20001 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 9 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 XNo If Yes, Give 1 Yes 2 XNo Specify: Specify: Black "natural" 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Providence Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James T. Plunkett Mary Alice Winbush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen D. Botts/Daughter 7002 17th Avenue, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Harmony Memorial 11/08/2010 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Wash., D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ Cerebrovascular Accident 10/21/2010 Medical Examiner HTN 05/20/2010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) GI Bleed 05/20/2010 death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Physician/Medical P.O. Box 68760 as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ģ Pregnant at time of death Dav Year the a Hospital or Attending Physician: The law requires that the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Anknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 2 🗌 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) ည 1 🗌 Yes 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, 24 hours after death Funeral Director: A completed filled in by the ithin 2 the I

> State Registrar

Medical

29a. Certifier (Check

29b. Signatu

only one)

31. Date filed (Month, Day, Year) NOV U9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

06

2010

3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harry M. Peden 1:30p M November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Bedford Court Nursing Home 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 **X** M 2 □ F Months Days Hours Director Washington. 579-18-0522 88 Usual Residence of Decedent If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 3416 Chiswick Court 20906 U.S.A within 72 hours after death 11. Marital Status 12 Was Decedent Ever in ILS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed WWII Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Naval Architect Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be filed If Health and Mental H Item 27 is marked ot Hugh L. Peden Sarah Hannig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3416 Chiswick Court. permit. Page 1 and Department of Heal Important: If item 2 any injury or other 1 Martha Peden - Spouse Silver Spring. Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 11/10/2010 | Silver Spring, MD e of Tuner I Sep/Ice Li Sign 22. Name and Address of Facility Hines-Rinaldi Funeral Home, shell 1 11800 New Hampshire Ave., Silver Spring, MD20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, for heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Coronary Artery Disease ears Medical Due to (or as a consequence of) Examine Diabetes Mellitus Type II Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed ne attending physician and ed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Pregnant at time of death Month signed by the aid be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease with Bilateral Leg 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Amputations. 24a. Was an has autopsy performed? **Director:** After this certificate I Essential Hupertension 1 Yes 2 No Yes 2 X No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗓 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a To the Funeral I Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

10+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3305 N.

M.D.

Burt Feldman,

NOV 09 2010

D23958

Leisure World Blvd., Silver Spring, Maryland 20906

November 08, 2010

## Amend 4b per OCME G911 1/3/11 dk

10-08489 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Linda Pershkow State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ November 6, 2010 0827 hrs Medical Examiner Linda S. Pershkow 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1801 E. Jefferson Street T20 **Bethesda** Montgomery Rockville If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 8/20/1941 Country) Brooklyn Director 131-32-4991 69 2 X F 1 M Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No 23a or 28a-f show notified at once. MD Montgomery Rockville 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. fitem 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1801 East Jefferston Street #T-20 20852 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Mantal Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. White Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes If Yes, Give Year 3 Widowed 4 X Divorced 1 Yes 2 X No specify: Specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Rosenberg Milton Samber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue NE Washington DC 20002 Barry Pershkow - son 656 Massachusetts 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, of I 1 Burial 2 Cremation 3 Removal from State Garden of Remembrance Memorial Park or other Pages 1 Department o 11/10/10 Clarksburg, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee M01163 ty E war Sage Funera 1 rection Pi e Rockvil e MD 20 5 22. Name and Address of Facil 1091 Rockville 23a. Patil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Venlafaxine, oxycodone and acetaminophen intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMSA,PII,27,28a-f,per ME g910 12/8/10 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown <u>Р</u> О signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown HYpertensive atherosclerotic cardiovascular disease Completed Records, peen page 2 should 24b. Were autopsy findings available 24a. Was an history of recent shoulder dislocation prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes ospital or Attending Physician: hours after death. funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 V Yes No <sup>28d</sup> Describe how injury occurred subject accidentally overdosed 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 Natural neral Director: A 1 Yes 2 XNo Pending Fd 9:10 Fd 11/6/10 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1801 E Jefferson St T20 Rockville, MD Suicide Could not be To the Hospital o within 24 hours aff To the Funeral Di determined found at residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 7, 2010 **OCME** 30. Name and address of person who completed cause of death (Item 23a) Mary G. Rippe MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) egistrar's Signa State

Registrar

Box 68760 P.O. Records, of Vital Hospital or Attending Division To the Hospital within 24 hours a To the Funeral C completed filled is

5+ State Registrar 3 Ē

Thomas E. Maslen,

NOV 1 2 2010

31. Date filed (Month, Day, Year)

MV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title o

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D55559

29c. License number

7525 Greenway Center Dr., S-312, Greenbelt, MD 20770

29d. Date signed (Month, Day, Year)

November 10, 2010

Registrar DHMH 17 Rev 7/2009

State

MIMA

31. Date filed (Month, Day, Year)

2010

enson

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Eliot P.Y. Powell 11:20 AM November 2010 4c. County of Death Anne Arundel 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ginger Cove Health Center Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 23, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1**XX**M 2 □ F 92 Months 226-26-0662 Washington DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Annapolis Maryland Anne Arundel 1 Yes 2xXNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21401 9210 River Crescent Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2000 Married 1 Yes 2 □ No If Yes, Give Ta7 White 1 ☐ Yes 2XX No Specify: Specify: WW II 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Real Estate Developer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Prankard Lester B. Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sara Powell/daughter 21144 8331 Dubbs Drive Severn, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burlal 2 Cremation 3 Removal from State Arlington Nat. Cemetery 2/4/2011 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Servi 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 week Immediate Cause (Final Pneumonia

Physician/ Medical **Examiner** 

Physician/

Medical

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Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

**Director** 

28a-f shov

filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

al Hygiene.

permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I

Baltimore, Maryland 21215-0036

Examine

Physician/Medical

Completed by

Be

Certificate: To

Medical

(Check only one 29b. Signature and titl

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death

NOV 082010

Paul B. Berez, MD

attending physician and for use as the burial-transit been signed by the should be detached has certificate this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

disease of condition		7 11-0-1								
resulting in death)	a. Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequence of):									
that initiated events resulting in death) Last	C. Due to (or as a consequence of):  d									
FFEMALE:   23b. Was decedent pregnant   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of domain the past 12 months?   1   Yes 2   No   9   Unknown   9   Unknown   9   Unknown   1   Unknown   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of domain the past 12 months?   Month   Month   1   M										
Part II. Other significant conditions of Dementia	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown									
Failure to the	rive	24a. Was an autopsy performed? 1 □ Yes ★★No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes ★★No 1 □ Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check o	nly one)								
examiner? 1 ☐ Yes 2 🔀 No	Hospital: Other:	e 5 Residence 6 Other (Specify)								
27. Manner of Death 1XX Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred								
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)	If, Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at the se Practioner: To the best of my knowledge, death occurred at the time, date and place,	le time, date and place, and due to the cause(s) and manner stated								

29c. License numbe

D0029571

Crofton, Maryland

29d. Date signed (Month, Day, Year,

November 5, 2010

State Registrar

JH 84

em 23a) (Type, Print)

2225E Defense Hwy.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day Physician/ 0115 France A. Pindell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Hours 1 🌠 M 2 🗆 F Janth, 135 Year 1921 Maryland 89 217-16-7160 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director 28a-f 1 Yes 2 No Marvland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 23a Funeral 21401 USA 58 Parole St. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: **Black** Specify: If Yes, Give Completed 3 Wildowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Building Contractor Self Employed æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Smith Jacob Pindell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md. 21401 58 Annapolis, Gwendolyn Pindell(Wife) Parole St. 20b. Bestugastur (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Memorial Park 11-9-10 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Marne Range Seof Additions Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Beese MOOY 8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ rator disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any list ing to immediate cause. Enter Underlying Cause (Disease or iinjury Exami burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to 24 hours at ler death.
• Funeral Director Affer this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the sid be detached f a Unknown gignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar

DHMH 17 Rev 7/2009

29b. Signature a

31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 09 2010

32. Registrar's Signature

29c. License number

20043371

10

0-08882		Please Type or Print in Black Indelible				2 N 1 1	
oseph C Popha		State of Maryland / Department		nd Mental	Hygiene	2010	3763
		1- For State Certificate Registrar	of Death		2. Date of Deat	eg. No.	3. Time of Death
Physicia Iedical Exami	41.0	1. Decedent's Name (First, Middle, Last)  Joseph C. Popham			Month November	Day Year	1718 hrs
ieulcai Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	r Location of De		4c. County of Deatl	1
		Anne Arundel Medical Center	Annapolis			Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				th (MM/DD/YYYY) 9. Bir	thplace (State or Foreign untry)
Director		214-92-8069 1XM 2_F 36	Yrs. Months Day	ys Hours M	September	er 5, 1974 Mai	ryland
,		Usual Residence of Decedent	antian.				10d. Inside City Limits
w su		10a. State 10b. County 10c. City, Town or Lot	cation				1 Yes 2 X No
Maryland 28a-f show any d at once.	호	Maryland Anne Arundel Arnold  10e. Street and Number	10f. Zip Code		110	0g. Citizen of What Cou	
ith the Maryland 23a or 28a-f sho notified at once	Director	865 Mill Creek Road	2101:	2		USA	
vith th	_		Was Decedent of Hi		Specify Yes or No-		ican Indian, Black,
eath v	Funera		If Yes, specify Cuba	n, Mexican, Pue	erto Rican, etc.)	White, etc.	
after d	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2X No	o specify:		Specify: Wh:	ite
nours		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent during	dent's Usual Occupa most of working life			16b. Kind of Business/	Industry
36 n 72 l nan ", lical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Musi	cian			Entertai	nment
-000 withing giene.	E	17. Father's Name (First, Middle, Last)		18.Mother's Na	me (First, Middle, N		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Jack L. Popham, Sr.		Patric	ia Hignut	tt	
21, ould b i Men s mar		19a. Informant's Name/Relationship (Type, Print )	iling Address (Stre	et and Number	or Rural Route Num	nber, City or Town, State	e, Zip Code)
MD id 2 sho lith and m 27 is aumati						, Maryland	
re, s 1 an of Hea If iten			position (Name of ce other place)	emetery,	Date	20c. Location - City or	Town, State
Page nent o		4 Donation 5 Other Specify: Hillcres	st Cemeter	ry 1	1/24/10	Annapolis	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once						Kalas Fune Edgewater,	
	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter				-	Approximate Interval
Physician Wedital		failure. List only one cause on each line.					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a.   Type Ttens Ive at the bull of the condition resulting in death)  Due to (or as a consequence of):	100010100	10 0010			
		Sequentially list conditions, b					
	ij.	If pry leading to immediate					
_ ;=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
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876 ificate ig phy is the b	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy live hirth	Fetal death 3		gnancy	23d. Date of deliver Month	y Day Year
Box 68760, e death certificate by the attending physic ed for use as the but	icia	Pregnant at time of death 5	Other (Specify)				
Bo ne deat the at	Physician/Medic	1 Yes 2 No 9 Unknown 9 Unknown		ninna in Bart I	Dan Didto	bacco use contribute to	the cause of death?
Division of Vital Records, P.O. is la to Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by ited in by the funeral director, page 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in the Chronic alcohol abuse	ie underlying cause	given in Part i.		s 2 No 3 Pro	
ords, I w requires us been sig should be	Completed by	Onfonie alconol abase			24a. Was a		utopsy findings available
SOFC law re has be	nple				autop perfor	rmed? death?	completion of cause of
Vital Recc ysician: The lar his certificate ha director, page 2	So		26 Dina	e of Death (Che	1 Yes	2 No 1 Y	es 2 No
'ital sician is cert irecto	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpati		101		Residence 6 Othe	r:
of V g Phy fter th	6	27. Manner of Death 28a. Date of Injury 28b. Time		ury at Work?		how injury occurred	
ion of tending Ph eath. tor: After t	tion	1 Natural 5 Pending (Month, Day,Year)	1	Yes 2 No			
ViSi or Att fter de Directe	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office	building, etc.	28f. Location (S or Town, S	Street and Number or Ru	ural Route Number, City
Di pital ours a filled	Certification:	4 Homicide determined (Specify)			0. 10		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		29a. Certifier (Check only one)  1 Certifying Physician. To the best of my knowledge, death or (Check only one)  2 Medical Examiner: On the basis of examination and/or investi	curred at the time, of	date and place, a	and due to the caus	se(s) and manner as state and place, and due to the	ed. ne cause(s)
To th within To th	Medical	and manner stated.  29b. Signature and title of certifier		se number	actio ono, dato	29d. Date signed (Mo	
	-	Part Dans		.M.E.		November 20, 2	
		30. Name and address of person who completed cause of death (Item 23a)				L	
His		Patricia Aronica-Pollak MD. Assistant Medical Examiner		treet, Baltim	nore, MD 2120	1	
S	tate	31. Date filed (Month, Day, Year) 37. Registrar's Signature 1. And 1. An	41				
Regis		MIIV Z. D. ZUIU - L. L. L. L. L. L. L. L. L. L. L. L. L.	LACA				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Antoinette Switzer Ruppert 7, 2010 Physician/ 10:50 A <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Hesketh Street Chevy Chase Montgomery 9. Birthplace (State or Foreign Country) West Virginia . Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 12/24/1918 1 □ M 2 🖾 F Months Hours 578-28-1047 91 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD Montgomery Chevy Chase 1¥ Yes 2 ☐ No 10f. Zip Code 20815 10g. Citizen of What Country? United States 10e Street and Number 11 Hesketh Street Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced than "natural", Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r. any injury or other traumatic event, the Merit <u>More.</u> College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Healthcare Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lawrence Switzer Sophia Wuchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Hesketh Street Chevy Chase, MD 20815 Caryl Ersenkal / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemet. 11/12/2010 Silver Spring, MD 4 Domation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funder 5130 Wisconsin Ave. NW Washington, DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Years Immediate Cause (Final Alzheimer's Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician a should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 E Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Parkinson's Disease, Coronary Artery Disease, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension sate has I page 2 s autopsy performed' hin 24 hours after death.

the Funeral Director; After this certificate I

mpleted filled in by the funeral director, pag 1 ☐ Yes 2 😾 No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 🔀 No Hospital Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 🗓 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours at To the Funeral Dir. Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

11/09/2010

D0026607

Registrar

DHMH 17 Rev 7/2009

Edward Cullen MD 7625 Wisconsin Avenue #101 Bethesda, MD 20814

Taward / Culles W.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ 11/4/2010 Year Louis D. Robinson 7:30 Medical 4a. Facility Name (if not institution, give street and number) Bethesda 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Health & Rehabilitation Center Bethesda <u>Montgomery</u> Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Hours Feb. 23 Director 228-40-4963 75 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1410 Buchanan ST NW 20011 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 X Yes 2 No
If Yes, Give
Year or Dates. WW 11 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. Completed 3 ₩ Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) perit. Page 1 and 2 should be filed within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Security Officer <u>Smithsonian Inst</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Robinson Cora Snead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) British A. Robinson / Daughter 4515 Willard Ave # 2102 Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/10 Falls Church, VA National Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Squamous Cell Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner inknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ anemia cate has been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown prepertension Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 2 Accider
3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after desured the Funeral Director of Funeral Dire

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOWDEURY, MD; 15216 DINO DRIVE, BURTONSVILLE, MD 20866 NURUL 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 09 2010 Registrar

D43121

29b. Signature and title of certifier

Christi

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			For State Registrar	state of IVI	aryıan	-	artment of I tificate of I		and Mental Hy	giene Reg. No.2010	37636	
			Decedent's Name (First, Middle, Last)				timodio or i		2. Date of De	ath	3. Time of Death	
	Physicia Medic		Betty Jean Reed							November 9, 2010 9:30 PM		
	Examin	er	<sup>4a</sup> Facility Name ( <i>If not institution, give stree</i> Benevolence Care Nu 15912 Fointer Ridg	rsing Hoed Road	ome			owie		4c. County of De Prince	George's	
	Funeral Director		5. Social Security Number  577-56-8048  1 □ M  Usual Residence of Decedent	2 ፟፟፟M F	69	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month. Da	v, Year) (	Birthplace (State or Foreign Country) shington, DC	
	aryland ia-f show	ector	10a. State 10b. County  Maryland Prince Geo	rge's	-	, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 4103 53rd Avenue,				10f. Zip Code	20710		10g. Citizen of What USA	Country?	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 🖾 Never Married 2 🗆 Married	Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		1	Was Decedent of H f Yes, specify Cub		in? (Specify Yes or No- Puerto Rican, etc.)		nerican Indian, nite, etc. White	
21215-0036	thin 72 hour ene. than "natu he Medical	Completed			+)	(Give	lent's Usual Occup kind of work done O NOT use retired,	during most of	of working	16b. Kind of Busines Telecommu	·	
<b>d</b> 2	led wi Hygid other ent, t	Be (	12 17. Father's Name (First, Middle, Last)			010	210	18. Mother	r's Name (First, Middle,	Maiden Surname)		
/lan	d be fi Mental arked rtic ev	2	Frederick Taylor R	.eed					e Ethel Mc			
Maryland	d 2 should alth and N 27 is me		19a. Informant's Name/Relationship (Type, F Judith L. Barker /				-		r or Rural Route Numbe		Zip Code)	
ore,	ge 1 an nt of He :: If item or othe		20a. Method of Disposition 1 ☐ Burial 2 🔯 Cremation 3 ☐ Rem	oval from State	Ce	emetery, cren	sition (Name of natory or other pla	ce)	Date 1/11/2010	20c. Location - City		
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	1.2.4	Met		an Cremato . Name and Addre	- :			a, Virginia	
8	Dep Imp		Lewis H &	Efma		Ga	asch's Fu	neral	Home, P.A.		le, MD 20781	
-	Physician/		23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	use on each line					ardiac or respiratory ar		Approximate Interval Between Onset and Death I YR 4 m 3	
-	) Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	ading to immediate Due to (or as a consequence of): Inter Underlying Jisease or linjury								
	executed ian and urial-transit	Exa	that initiated events c resulting in death) Last	Due to (or as a	consequ	ence of):						
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Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 24 hours after death certificate has been signed by the attending physici tred filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but and filled in by the funeral director, page 2 should be detached for use as the but and filled in by the funeral director, page 2 should be detached for use as the but and filled in by the funeral director, page 2 should be detached for use as the but and filled in by the funeral director.	Physician/Medica	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1									
, P.O.	es that the igned by be detact	þ	Part II. Other significant conditions contrib	uting to death b	ut not resi	ulting in the u	nderlying cause gi	iven in Part I.			to the cause of death?  Probably 4  Unknown	
rds	requires the been signer should be a	etec							24a. Was		autopsy findings available	
of Vital Records,	The law ate has page 2 :	Completed							autoj perfo	osy prior to ormed? death	o completion of cause of	
Tal.	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?						(Check only one)	2/11/0	63 2 110	
N.	Physic this of	은	1 Yes 2 No	1 🗌 Inpatie		ER/Outpatier		4 Nur	sing Home 5 - Resid	dence 6 Other (Sp	ecify)	
ion of	ktending Ph death. ctor: After thi y the funeral	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injur (Month, Day		28b. Time of injury	28c. Injui wor M 1			now injury occurred		
Division	tal or Atten rs after deat al Director: ed in by the		4 Homicide determined	8e. Place of Inju building, etc			eet, factory, office	factory, office 28f. Location (Street and Number or Rural Rou City or Town, State)				
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 0 Medical Examiner: 0 Certifying Nurse Pra	To the best of on On the basis of exactioner: To the l	my knowle kamination best of my	edge, death o and/or invest knowledge, o	occured at the time igation, in my opini leath occurred at th	e, date and pl on, death occ ne time, date a	lace, and due to the ca curred at the time, date a and place, and due to th	use(s) and manner as and place, and due to the e cause(s) and manner	stated. e cause(s) and manner stated. as stated.	
0	To the To the Comple		29b. Signature and title of certifier  25 L Clew So	1 msi	1 ca	-NP	29c. Licens	e number	000	29d. Date signed (Mo	e cause(s) and manner stated. as stated.  nth, Day, Year)  (have MD  ST N2-B7	
	80		30. Name and address of person who compl	eted cause of de	eath (Item	23a) (Type, F	rint) 5m	507=+	10000000 Y 601 N.	CAROUNE	ST 2287	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure Sank	·					
DHN	MH 17 Rev 7/20	_	MUTA & ZOIO A	STOCK OF THE PARTY	10.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ 01: 12 A M 2010 Ronald Oliver Shirev NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 2, 1940 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Hours Min. Pennsylvania 210-30-2375 Director 70 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21742 20108 Cherry Hill Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian was Decedent Ever III 0.5
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 1959—
Year or Dates. 1966 Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) <u> Vice President</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Roseanne Anderson Shirey Oliver Morris Shirey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20108 Cherry Hill Dr. Hagerstown, MD 21742 Sandra R. Shirey-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-20-2010 Rest Haven Cemetery Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signal > of Funeral Service Licenses Eastern Blvd. North Hagerstown. MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has page 2 1 Yes Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. 26. Place of Death (Check only one) Be Hospital: 2 No 1 Tyes ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2 2010

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Registrar

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

NOV 16

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egistrar's Signature

Division of Vital Records, P.O. Box 68760

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		For State Registrar						ificate			<del>,</del>	Reg. N	0.0	110		
Physicia		1. Decedent's Name			RINGER						2. Date of De		Y, 2	OTO	3. Time of 4:30	
Medic Examin		4a. Facility Name (if 1613 Two			nber)			4b. City, Town, or Location of Death Rockville						y of Death		
Funeral Director		5. Social Security No.	umber	6. Sex 1 <b>[</b> √] M 2 □ F	7. Age (In y			If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	rth ay Year)	1936	g. Birth	k <sup>t</sup> yn,	or Foreign
		Usual Residence of 10a. State				. City, Tow		ation		1	Treb. Z	,	1300	- 1	10d. Inside Ci	
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with the 23a or	eral D	10e. Street and Nun						10f. Zip					itizen of I.S.F	What Cou	intry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1  Never Marri 3  Widowed		12. Was Decrired 1 □ Yes If Yes, Gir Year or D	orces? 2 X No ve	ı U.S.	lf '	Yes, spec	ify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	-		ck, White,	can Indian, etc. hite	
72 hours "natur ledical l	Completed	(Spe		nt's Education est grade completed		16a	(Give ki	ent's Usua ind of wor	rk done d	ation luring most of wor	king	16b.	Kind of E	Business Ir	ndustry	
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d be filed fental H irked ott tic even	To Be	17. Father's Name (First, Middle, Last)  Samuel Springer  Belle Levine									ne)					
2 should th and N 27 is ma trauma			9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1613 Tweed St., Rockville, MD 20851													
age 1 and nt of Heal t: If item ? / or other		20a. Method of Disp 1 <b>X</b> Burial 2	oosition	3 Removal from	State JL	ob. Place o cemete idean	f Disposi	ition <i>(N</i> a <i>n</i>	ne of	1	Date 2,2010	20c.			own, State	
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or Attendater deat Director: In by the	Certificate:	2  Accident 3  Suicide 4  Homicide	Investi 6  Could determ	not be 28e. Place	e of Injury - Aing, etc. (Sp		arm, stree			100 2 110	28f. Location ( City or To			ber or Rura	al Route Numb	ber,
Hospital 24 hours Funeral Feted filled	Medical	(Check 2	🔲 Medical I	Physician: To the lexaminer: On the ba	sis of examin	nation and/o	or investi	gation, in	my opinic	on, death occurred	at the time, date	and plac	e, and di	ue to the c	ause(s) and ma	anner stated.
To the comp	2	29b. Signature and		M	D		94,		. License	39639	,	29d. D		ed (Month,	Day, Year)	
		30. Name and addr	ress of person	who completed cau	se of death	(Item 23a)	(Type, Pr	int)	ore !	15 an	201					
Stat Registra		31. Date filed (Mont		32.	Registrar's S		A.C.	Made	7							

State of Maryland / Department of Health and Mental Hygiene [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:02P 2010 Frances C. Sonnino November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery 701 Downs Drive Silver Spring 8. Date of Birth (Month, Pay, Yea May 29, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. washington. 96 579-03-1255 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Silver Spring Maryland Montaomeru 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 701 Downs Drive U.S.A. 20904 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Advertising & Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Publishing Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Theresa Catalano Antonio Cosimano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Kirby Road, Bethesda, Maryland 20817 Daniel F. Sonnino - Son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Lincoln Mausoleum 11/16/2010 Brentwood, Maryland 4 Donation 5 & Other (Speck) Entombment Ft. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Si Inature of Funeral Servic - Licens -MUDTU 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final es leufold Physician/ disease or condition Medical resulting in death) Due to (or as a con wince of): Examiner Sequentially list conditions, if any, had ing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events could be indeed by last Examine the attending physician and the for use as the burial transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death Unknown g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 11 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chevy Chase, Maryland 20815 M.D 5550 Friendship Blvd.. Robert Hardi. 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 12 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		irtment of Hea			2	nin	3761.0	
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	inicate of Dea	<del>au -</del>	2. Date of Dea	Reg. No. 🛴	UIU	3. Time of Death	
	Physicia	n/	OYANA STEPHENS				1 <sup>M</sup> 2705/		Year	11:30 P M	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death			ty of Death	<del>-</del>	
	Examin	er	19806 Shady Brook Way		Gaithersb				gomer		
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. Ia.	st birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birtl	)	g. Birth	place (State or Foreign	
	Director		203-54-2212 1□M 2 XF 36	Yrs.	Months Days H	lours Min.	Month, Day 08/07/	1974	DC DC	ntry)	
	d low ft	_	Usual Residence of Decedent           10a, State         10b. County         10c. City	, Town or Loc	ation			_		10d. Inside City Limits	
	arylar a-f st fied a	Director								1 X Yes 2 □ No	
	or 28 noti	The state of the s									
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	tems er m	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							ace - American Indian,		
9	fter d ", or i amin	1 Never Married 2 M Married 1 Yes 2 No									
Ö	within 72 hours after death with the Maryland glene et than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.						BI	ack	
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/lar	d be Venta	욘	Armstead Galiber, Sr.		uk	in					
lan.	12 should be file lith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and I			-			
2	and 2 Health em 27 ther tr		Nigel Stephens - husband  20a. Method of Disposition 20b. Pl		Major Dent				·		
Baltimore, Maryland 21215-0036	Page 1 ament of hant: If its		1 ☐ Buriai 2 🛛 Cremation 3 ☐ Removal from State 🧣	metery, cren	sition (Name of actory or other place)	İ	eate	20c. Location	-		
탪	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur :: uneral Service License (Specify)		remation Sv Name and Address of			Hanove:			
Ba	permi Depar Impo any ir once.		> Herede Samuel	1	ló N. Washi						
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. that only one cause on each line.							Approximate	
-4	hysician/		Immediate Cause (Final disease or condition Carcinoma Co	f the	stomach wi	th meta	stasis			Interval Between Onset and Death	
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09	eath certificate be executed attending physician and for use as the burial-transit	dical	d								
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Box 687	h cert tendir ir use	an/l	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal	death 3	Ectopic pregnancy				ate of deliv		
Bo	e deat the at ned fo	Physician/Me	1 ☐ Yes 2 🛣No 9 ☐ Unknown 9 ☐ Unknown	eath 5 L	Other (specify)			IV	lonth	Day Year	
o.	es that the dec signed by the a be detached f		Part II. Other significant conditions contributing to death but not resu	Ilting in the u	nderlying cause given in	in Part I.	23e. Did to	bacco use cor	ntribute to t	he cause of death?	
S, F	ires the signer of the signer	d by					1 🗆 \	′es 2 □ No	3 🗆 Pro	obably 4 XUnknown	
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<u>e</u>	an: T rtifica tor, p	Be C	25. Was case referred to medical examiner?		26. Place	of Death (Check		2 110	1 🗆 103	2 110	
Ζ̈́	nysician: The lavinis certificate ha	70 E	1 Yes 2 X No 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Other: 4	4 ☐ Nursing Hor	me 5 🗌 Resid	ence 6 XOt	her (Specif	parent home	
of	ding Phy th. After this funeral of	ate:	27. Manner of Death  1   Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?		8d. Describe h	ow injury occu	rred		
ion	tend death tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ma farm atra		2 🗆 No	205  +: (0	t	6	J. Davida Aliyahar	
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificar within 24 hours after death.  We the Fundar Birector: After this certificate has been signed by the attending of completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Cer	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office	1	City or Tow		per or Hura	al Route Number,	
	the Hospital hin 24 hours at the Funeral I	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowle								
	he Ho lin 24 he Fu hplete	Mec	(Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practioner: To the best of my								
			29b. Signature and title of certifier		29c. License nur			29d. Date sign		Day, Year)	
	5		Thereof I down	00.1=	D00555	522		11/08/	Τ0		
			30. Name and address of person who completed cause of death (Item Robert H. Gerard, MD 1500 For	est G	len Road, S	Silver S	pring,	MD 209	10		
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signal	re L	N.S						
	Registra	ar	NOV 1 0 2010 Comm A	19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per FH G910 12/08/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 08, Morton J. Simons 2010 1:05 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Montgomery General Hospital Olney 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign S087-16-4840 **Funeral** New York Days 1 X M 2 □ F Months Hours Min. (Month Pay / 1924 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No Maryland Montgomery Silver Spring 10e. Street and Numbe 10g, Citizen of What Country? Funeral 3100 North Leisure World Blvd., #901 20906 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 WWII 1 ☐ Yes 2 X No Specify: 3 Divorced Completed White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Broker Insurance Brokerage Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Jacob Simons Nettie Menzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 N. Leisure World Blvd #901, Silver Spring, Helen S. Simons - Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdns: 11/10/2010 | 4 Donation 5 Other (Specify) Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Ameparenario 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Advanced Ph\_sician/ Pancreatic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Matural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20+1 00068026 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

PANMATA BANDI 18101 Prince philip Drive, olney, MD - 20832 PADMAJA Prince 18101

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Regist AMEND#25, 27, 29dperMD11/10/10, EMV, MccCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth 03-2010 Lamont Simms 13:21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 1**X** M 2 □ F . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 12-10-1961 Hours Min. 579-88-8929 Washington DC Director 48 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland anter of Health and Mental Hygiene. ant. If item 27 15 marked other than "natural", or items 23a or 28a-f show ant. If item 27 15 marked other than "natural", or items 25a or 28a-f show up, or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George 1 X Yes 2 No Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11920 Twin Lakes Drive #1 20705 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify. Specify.Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Lemon Delores Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Simms - wife 3922 Dunes Way Burtonsville, Maryland 20866 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 20b. Place of Disposition (ivarine of cemetery, crematory or other place)

Chesapeake Crematory 11-10-10 1 Burial 2 X Cremation 3 Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Sen 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician respiratera disease or condition resulting in death) Medical Due to (or as Examine Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or linjury that in the light of the Examiner signed by the attending physician and doe detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed<sup>4</sup> ours after death.

eral Director: After this certificate I filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital on within 24 hours at To the Funeral Di Medical Artifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO Frank pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who New Humpshire termen Suite 2 NOOZ Mb 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State
Registrar AMFND#23 coerMD, 11/18/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ 570mm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Itolu Cross. Nurs. Ration Ge Montgomery **Burtonsville** 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 28-Months Min. Juneth, 5 ay, 1916 South Carolina 881 **Director** Defemit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgomery Silver Spring 10f. Zip Code 10e, Street and Number 10q. Citizen of What Country? Funeral 20904 416 Kimblewick Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African Specify American 1 Never Married 2 Married þ Reltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed DO NOT use retired)
Housekeeper Elementary/Seconday (0-12) College (1-4 or 5+) Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Rickenbacker Annie Stafford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8838 Blue Sea Drive, Columbia, MD 21046 Barbara M. Murray/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln 10/29/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1xem10 Medical Due to (or as a consequence of): Examiner gestive Sequentially list conditions, Examine o for 85 8 Consequence of cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last an/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 signed by the attending physid be detached for use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 5 Other (specify) Physici 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 2/No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner's 2/1 No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending (Month, Day, Year) Accident Investigation the 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 251 00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Annu #117, SILVERSPRING MDZOGOZ Sunitha Bhogavilli

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 09

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#23a-II perMD, 11/9/10, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ Lamendola Stafford Lena 3Ĭ 2010<sup>rea</sup> 1:16 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maplewood Assisted Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🛣 I Hours Min. 1071271920 Country) Kansas Director 513-12-2558 90 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9707 Old Georgetown Road # 109 20814 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces 1 ☐ Yes 2X☐ No If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: d Mental Hygiene. marked other than "natural", 3₺ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Administrative Asst.</u> Goverment Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leonard Lamendola Anna Vandris Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clair W. Rodgers / Son .520 Wohlgemuth, Lusby MD 20617 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/5/2010 4 Donation 5 Other (Specify) Falls Church, VA National Crematory P Signature of Funeral Service Lice 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Parkinsons Disease End Stage Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death a ☐ Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by - Aspiration 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6% Other (Specify Asst. Living 2X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA ompleted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 XNatural injury work? 2 🗆 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 10 D35791 11/01/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Georgia Ave # 227 Silver Spring, Md 20902

MD 9801

32. Registrar's Signature

Merlyn Vemury
31. Date filed (Month, Day, Year)

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## Agitimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Physician Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Owithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physic Med Exam

Funera Directo

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.								
	For State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg No. 2014								
	1. Decedent's Name (First, Middle, Last)  2. Date of Death 2 3. Time of Death 3								
an/ cal	Isadore SHAPIRO November 8°, 2010° 12:40 P.M								
ner	4a. Facility Name (if not institution, give street and number)  Renaissance Gardens  4b. City, Town, or Location of Death Silver Spring  4c. County of Death Prince Georges								
	5. Social Security Number 16. Sex 1 Months Days Hours Min. J. Mag. 1927 Pennsylvania  1. Security Number 1.								
tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
Direct	laryland     Prince Georges     Silver Spring     1 □ Yes 2 □ XNo       10e. Street and Number     10f. Zip Code     10g. Citizen of What Country?								
eral	3160 Gracefield Rd. 20904 U.S.A.								
ed by Fur	10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits   10d. Inside City Limits   10d. Street and Number   10f. Zip Code   10g. Citizen of What Country?   10f. Zip Code   10g. Citizen of What Country?   10f. Zip Code   10g. Citizen of What Country?   10d. Inside City Limits								
mplet	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business Industry								
Be Co	Elementary/Seconday (0-12) College 2-4 or 5+) Engineer U.S. Government								
To B	17. Father's Name (First, Middle, Last) Samuel Shapiro  18. Mother's Name (First, Middle, Maiden Surname) Ida Latinsky								
	19a. Informant's Name/Relationship (Type, Print) Sharon Alpert / daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13706 Ginkgo Terr., Rockville, Md. 20850								
	20a. Method of Disposition    20b. Place of Disposition (Name of Date   Date								
	21. Signature of Funeral Service Utensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Parkinson's Disease  Due to (or as a consequence of):								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):								
_	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):								
Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live Birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery   Month Day Year								
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Coronary Artery Disease  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   X No   3   Probably   4   Unknown								
Complet	24a. Was an autopsy performed?  1 \( \text{Yes} \) 2 \( \text{N} \) No \( \text{Yes} \) 2 \( \text{N} \) No \( \text{N} \) No \( \text{Yes} \) 2 \( \text{N} \) No \( \text{N} \)								
	25. Was case referred to medical examiner?  1   Yes   2   X   No								
ate: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work? 28d. Describe how injury occurred								
Medical Certificate: To	2 Accident Investigation 3 Suicide 6 Could not be determined								
Medical	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)								
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, I									

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Eileen Gemmell CRNP

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eileen Gemmell CRNP 3160 Gracefield Rd., Silver Spring, Md. 20904

0-08484	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.												
ilberto Salamano			tate of Maryl	and / Depa	artment of	Health					_	010	37646
Physiciar Medical Examin	n/	Registrar  1. Decedent's Name (First, Middle Gilberto			rtificate of alamano		_			Date of Dea Month Novembe		Year	3. Time of Death 0654 hrs
neuicai Examini		4a. Facility Name (if not instituti				b. City, Tow	n, or Lo	ocation of		Novembe	4c. Cou	inty of Deatl	h
E		Prince George's Hos	pital Center	7. Age (In yrs. I	last birthday)	Cheverly If Under 1		If Under	24Hrs	8 Date of Ri		ce George	e'S thplace (State or Foreign
Funeral Director	L	578-11-0735	1 M 2 F	46	Yrs.		Days	Hours	Min.		/1964	Εſ°	Salvador
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with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 14624 Carona	a Drive			10f. Zip Co 20	de 905	5			l0g. Citizen d	of What Cou	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other transattic event, the Medical Examiner must be notified at one.	ᇹ	11. Marital Status 1 Never Married 2 X	farried Armed F	2 🔀 No	If Ye	es, specify C $\to E  1$	uban, N Sa]	Mexican F LVado	uerto Ri	cify Yes or No can, etc.)	\	Race - American Indian, Black, White, etc. White	
urs afte	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)											cify: of Business/	Industry
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Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other transmati	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2												Town, State Spring, Md
Balti permit. Departm Imports injury o	21 Signature of Funeral Service Licenses PANTE and Address Reprivation Funeral Silver (9241 Columbia Blvd.Silver (9241 Columbia B												CE,P.A. ng,Md20910
Physician /M ai al		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.		. Do not enter the	e mode of dy	ing, su	ich as card	diac or re	espiratory arr	est, shock, o	r heart	Approximate Interval Between Onset and Death
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6 be exectly sician and burial - tr	edic	UNPENDED	AMENDED								100 1 0 -1	6 4-8	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executing 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending physician are completely filled in by the funeral director, page 2 should be detached for use as the burial in completely filled in the funeral director, page 2 should by the funeral director, page 2 should be detached for use as the burial in the funeral director, page 2 should be detached for use as the burial in the funeral director, page 2 should be detached for use as the burial in the funeral director.	sician/	F FEMALE: 3b. Was decedent pregnant in t past 12 months?  1 Yes 2 No 9 Un	he 1 Live	nant at time of de	2 Feta	al death er (Specify)	3	Ectopic p	regnanc	у	Moni	te of delivery	y Day Year
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Vital Reconsider: The land his certificate had director, page 2	24a. Was an autopsy performed?    24b. Were autopsy performed?										es 2 No		
Vita hysician this cer		examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient			hor:			Residence	6 Other	<u> </u>
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Di To the Hospital Within 24 hours To the Funeral completely filled	ਰ ੀ		hysician: To the be miner: On the basis and manner:	of examination a									
4	Me Z	29b. Signature and title of certif		Stated,		29c. Lio	ense r					signed (Mo	nth, Day,Year) 10
OCME	3	80. Name and address of person Mary G. Ripple MD.	who completed cau Deputy Chief	,		Penn Str	eet. E	3altimor	e, MD	21201	L		
Stat Registra	~	31. Date filed (Month. Day Year)		egistrar's Signatu		and a land							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia	n/	1. Decedent's Name (First, Middle MARGARET NE					2. Date of Deat Month	Day Year	3. Time of Death  1., 50 A M						
7	Medic Examin		4a. Facility Name (if not institution			4b. City, Town, or	Location of Death	111	4c, County of Dea							
	)	<b>.</b>	PRINCE GEORGE'			CHEVERI			PRINCE (	GEORGE'S						
	Funeral Director		5. Social Security Number 577–30–3352	6. Sex 1 ☐ M 2 🖾 F 7. Age (In	yrs. last birthday)  1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, JUNE 19,		thplace (State or Foreign (LSTANA						
	and show	ō	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits						
	Maryle 28a-f : otified	Director	MD PRINCE	GEORGE'S	HYATTSVI	LLE				1 🏋 Yes 2 □ No						
	h the	al Di	10e. Street and Number		· · ·	10f. Zip Code			10g. Citizen of What Co	ountry?						
	ath wit	Funeral	7304 LANDOVER R	D, #D  12. Was Decedent Ever	in 11 9 13 1	20785		ocify Yes or No-	USA 14. Race - Ame	orioan Indian						
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Never Married 2 ☐ Married 3 1 Widowed 4 ☐ Divorced	Armed Forces?		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🛣 No		Rican, etc.)	Black, Whit	e, etc.						
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yla	uld be I Ment narke	2	GUY NELSON					T NELSO								
Ma	2 sho Ith and 27 is r r traun		19a. Informant's Name/Relationsh KISER HARRIS,			•			City or Town, State, Zi							
Baltimore,	of Head of Head Fitem		20a. Method of Disposition  1  Burial 2  Cremation	T	20b. Place of Dispo	sition (Name of natory or other place	-)	Date	20c. Location - City or	Town, State						
ii	Page ment tant: It		4 Donation 5 Other (S	pecify)	CHESAPEAKE	CREMATORY	11/1		BELTSVILLE, M							
Balt	permit Depart Impor any in		21. Signature of Funeral Service L	2 Landi	71	6 KENNEDY S	STREET, NW,	WASHING	JENKINS FUN GTON, DC 20							
			3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													
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Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	23c. If yes, outcome of p	JFetal death 3 L	Ectopic pregnancy Other (specify)	4		23d. Date of de Month	elivery Day Year						
•	at the d by the letache		9 ☐ Unknown  Part II. Other significant condition		ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?						
S, F	uires the signeral de contraction of the contractio	ed by						1 🗆 Ye	es 2 🌠 No 3 🗆 F	Probably 4 🗆 Unknown						
·	w requisible beer 2 shou	Completed			_			24a. Was a	n 24b. Were au	utopsy findings available completion of cause of						
Sec.	The la ate ha page 2	Com						perform	med? death?	s 2 🗆 No						
ital	ician: pertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		l Out-	ce of Death (Check									
of V	Phys er this eral dir	e: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 X Inpatient 28a. Date of injury	2 ER/Outpatier 28b. Time of	28c. Injury	4 ∐ Nursing Ho		ence 6 Other (Spec ow injury occurred	cify)						
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$\lambda_{\mathcal{Z}}$ $\beta_{\mathcal{A}}$ $\lambda_{\mathcal{C}}$ $\lambda_{\mathcal{C}}$ Division of Vital Records, P.O	al or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ıral Route Number,						
H()	the Hospital or nin 24 hours afte the Funeral Dire	Medical	(Check 2 Medical E	Physician: To the best of my examiner: On the basis of exam Nurse Practioner: To the bes	ination and/or inves	tigation, in my opinio	n, death occurred at	t the time, date an	d place, and due to the	cause(s) and manner stated.						
(	To the comp	2	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mont	h, Day, Year)						
	2			R Brook			19183		Nov 4,	9010						
	ÆL.		30. Name and address of person Karen R. Brooks	, Md, Prince	George's	Hospital	, 3001 Ho	spital I	Or., Cheverly	, Md 20785						
	Stat Registra		31. Date filed (Month, Day, Year) <b>NOV 1 2 20</b>	32. Registrar's	Signature Sax	V										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ETHEL SELLMAN November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Regional Prince George's Laurel Laurel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Months Days (Month, Day, Year) Hours Min 1 □ M 2 😾 F 85 213-40-7229 Director 1925 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must he matified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No LANHAM MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 USA 9206 KIMBARK AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. BLACK Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 7 th College (1-4 or 5+) PRIVATE HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BESSIE JACKSON CLAYTON BURROUGHS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9206 KIMBARK AVENUE LANHAM, MARYLAND 20706 ETHEL ETHERIDGE/DGT. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State 11/13/2010 BRANDYWINE, MARYLAND 4 Donation 5 Other (Specify) CHURCH CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service License LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 a Mane 7474 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardin or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final +Tiysiciaii disease or condition Medical resulting in death) as a conse. Ince of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Year be detached for 5 Other (specify) Month Dav Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 No After this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No |은 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director A

completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital on within 24 hours off To the Funeral Dis Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed/(Month, Day, Year) D70093

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2010

32. Registrar's Signature

7300 Van Dusen

Laurell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 17:01 PM Nov. 4, 2010 VANCE STURGIS CURTIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Somerset 10696 Oriole Back Road Princess Anne If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** M 2□F Months 7,1946 Maryland Director 217-44-1591 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Princess Anne Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a U.S. 21853 10696 Oriole Back Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No 1964If Yes, Give 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: White 2 3 ☐ Widowed 4 ☐ Divorced 1970 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State Employee Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Sturgis Curtis Vance Sturgis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10696 Oriole Back Road, Princess Anne, Md. 21853 Ruth Ellen Sturgis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11-09-10 Princess Anne, Md. 4 Donation 5 Dother (Specify) Beechwood Cemetery 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licensee 11673 Somerset Ave, Princess Anne, Md. 21853 M00295 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Importate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASLULAR WISEASE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending phase for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9☐ Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★ No 24a. Was an autopsy performed? Yes 2 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATYAL, MI) 1004 POCOMOKE CITY SHARAD R.

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifler

32. Registrar's Signature NOV 1 0 2010

satyal mi)

29c. License number

00062172

MI)

29d. Date signed (Month, Day, Year)

11/5/2010

MARKET

Registrar

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mab Month 2010 Physician/ Day 9:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 626 Burley Road Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2🏋 F 84 0970671926 Wisconsin **Director** 399-30-6785 Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 626 Burley Road 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Never Married 2 Married 2 XNo Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XX No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medicine 12 03 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Frank M. Staeck <u>Margaret Kennedy</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph R. Skarwecki Son 626 Burley Road Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/08/2010 Glen\_Burnie,MD Signature of Suneral Service Licenses 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. Oak 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Year Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion abusiness. by the attending physician and stached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2-No Month Year 5 Other (specify) Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to 1 ☐ Yes ∠-☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 2XNo 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Z No Hospital Other: 잍 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6  $\square$  Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Jule 20 Brought 2003 Medi Rhou

Registrar

31. Date filed (Month)

NOV 0.9 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Novembery Physician/ 1650 2010 Yen Tao Bai Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** montgomer Rockville HOSDITO! Grove Adventist 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y April 24 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min Director 216-33-1002 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location the Maryland Director must be notified 1 X Yes 2 No Germantown Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Numbe 23a Funeral with U.S.A 20876 <u> 20805 Amber Ridge Drive</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces "natural", or 1 Never Married 2 X Married Yes 2 X No Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Asian the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. 3altimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Entrepreneur 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unknown) (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20805 Amber Ridge Drive, Germantown, Maryland 20876 Chiang Ting Hsu Tao - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State 90 Lincoln Crematory 11/11/2010 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Crem. 21. Signature of Funeral Service Licens e MO #1070 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Physician/ Asystolic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 24 hours Shoc diogenic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events The law requires that the death certificate be executed Myocard and Due to (or as a consequence of) resulting in death) Last attending physician at for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death ed by the a 9 Unknown s been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Holmknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has performed Yes 2 hours after death. Ineral Director: After this certificate to d filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X-No 1 Finpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural vatural
Accident
Suic 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cohen Rockville Car Dr mD 9901 medical 31. Date filed (Month, Day, Year) State NOV 1 0 2010 Registra

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	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2010 37652													
	DI		Decedent's Name (First, Middle, Last)	··-·	-				2. Date of De	ath	V	3. Time of Death		
	Physicia Medic		Brinda Sue Ta						Novemb	er P 2	o <u>ľď</u>	9:23 Рм		
2	Examin		4a. Facility Name (if not institution, give street and Frederick Memori	•	al		Fr	eation of Death		4c. County Fr	of Death ederi	ck		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔯	7. Age (In yrs. Ias	st birthday) Yrs.	If Under 1 Months		Hours Min.	8. Date of Bir (Month, Da March	th Year 1959	9. Birthp Flor	place (State or Foreign try) 1da		
pu	how	٦	Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Loc	ation					1	0d. Inside City Limits		
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the	a or 2 be no	Ē	10e. Street and Number			10f. Zip C				10g. Citizen of				
th with	ns 23 must	Funeral Director	801 Central Avenue				254			United	State	S		
<b>UUSO</b> urs after dea'	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status  1												
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r y ra	d Meni marke natic	은	John Norman Tabor		1				lizabet					
, Mid nd 2 sho	ealth an n 27 is i		19a. Informant's Name/Relationship (Type, Print) Paul Marinaccio / Son							r, City or Town, S 5, WV 25		Code)		
Page 1 ar	nent of He int: If iter iry or oth		20a. Method of Disposition  1   ■ Burial 2   Cremation 3   Removal  4   Donation   Other (Specify)	from State	ace of Dispos Meterrian emorial	ren or other	er place)	Nov.	Date 11, 010	20c. Location		own, State Maryland		
<b>Daltimor</b> permit. Page 1	Departri Importa any inju once.		21. Signature Funda Se ice Licensee					-				y P.A., MD 21701		
			23a. Part 1. Enter the disease or complications to shock, or heart failure. List only one cause of	hat caused the death							JI ICK	Approximate Interval Between		
	ysician/	Ø 1	Immediate Cause (Final disease or condition	$(I \cup I)I = I$	2gan	fa	. Cu	ne				Onset and Death		
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pe exe	ician a burial-	dical Examiner	resulting in death) Last Du	e to (or as a consequ	ence oty:									
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<b>BOX 00</b> 1 e death certific	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	in the past 12 months?	, outcome of pregnar Live Birth 2 ☐ Fetal Pregnant at time of do Unknown	death 3	Ectopic pre Other (spec				1	ate of delive onth	ery Day Year		
that the	ed by detac	y Ph	Part II. Other significant conditions contributing	to death but not resu	ılting in the ur	nderlying cau	use given	in Part I.	23e. Did t	obacco use cont	ribute to th	ne cause of death?		
dS,	en sigr uld be	ed b	1) Metarfater	lung	cem	un	7		1 🗆	Yes 2 □ No	3 Prob	pably 4 🗆 Unknown		
<b>4ecords,</b> The law required	ite has bei	omplet	2 Superion	vena c	care	çg.	dr	ione	24a. Was auto perfo	psy ormed?	Were autop prior to co death? 1  Yes	psy findings available mpletion of cause of		
VITAI IN ysician: Th	ertifica ector, p	Be C	25. Was case referred to medical examiner?					of Death (Check		2,E NO	100	2 110		
T VI	this c	요		1 Inpatient 2 1	ER/Outpatien					dence 6 Oth		)		
nding Pt	ith. : After e fune	cate		Month, Day, Year)	injury	M 200	i. Injury at work? 1 ☐ Yes	s 2 🗆 No	28a. Describe i	now injury occur	ea			
UIVISION tal or Attendi	after des <b>Director</b> d in by th	Certificate:	3 Suicide 6 Could not be determined 28e.	er or Rural	Route Number,									
Hospita	24 hours Funeral eted filled	Medical	29a. Certifier 1 Certifying Physician: To (Check only one) 3 Certifying Nurse Practic	e basis of examination	and/or investi	igation, in my	opinion,	death occurred a	t the time, date	and place, and du	e to the car	use(s) and manner stated.		
To the	within <b>To the</b> compl	Σ	only one) 3 Certifying Nurse Practice  29b. Signature and title of certifier	ner: To the best of my	knowleage, a		icense nu		ce, and due to tr	29d. Date signe				
			1 Kalgeen	7		D	65	378		11/05	/20	10		
	j		30. Name and address of person who completed Lev Agarunov	cause of death (Item	23a) (Type, P			Frede	rick.	mo	2170	21		
	Stat			2. Registrar's Signati	ure A	la co. to	رزا	,			~ , ((			
	Registra	ar	INON TE ZOIL	Comina	p.	Jeann								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Marylar State Amend Item 25 per me,g91	nd / Depa <b>5 ,05,406</b>	rtment of H	ealth and M eath	lental Hyو ا	giene 20 Reg. No.	10	37653				
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th	Voor	3, Time of Death				
	Physicia Medic		MILDRED ELVERTA TRUE				11	09 2	010	7:06 P M				
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I			4c. County		NET.				
-index	_		5. Social Security Number   6. Sex   7. Age (In yrs.	last hirthday)	CHURCHTO	If Under 24 Hrs.	8. Date of Birt	ANNE		place (State or Foreign				
	Funeral Director		236-24-9561 1 □ M 2 🖾 F 88	Yrs.	Months Days	Hours Min.	10/10/1	922	$\mathtt{WE}\mathbf{ST}^{Coun}$	VIRGINIA				
	, MC	. h	Usual Residence of Decedent	ity. Town or Loc	-41				1	0d. Inside City Limits				
	nyland I-f she ied at	cto	, our state	URCHTON						1 Yes 2 □ No				
	he Ma or 28a notif	Director	10e, Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?				
	with t	Funeral	5617 BATTEE DRIVE		20733			USA						
	leath items er m	ᇤ	11. Marital Status 12. Was Decedent Ever in U Armed Forces?		Vas Decedent of His Yes, specify Cuban				ce - Americ					
36	after (I", or xamir	d by	1 Never Married 2 Married 1 Yes 2 X No If Yes, Give	1	☐ Yes 2X No	Specify:			Specify: CAUCASIAN					
9	hours latura ical E	lete	15. Decedent's Education		ent's Usual Occupa			16b. Kind of E	Business Inc	dustry				
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21	d with lygien ther tl nt, the	Be C	12 TH 17. Father's Name (First, Middle, Last)	DI OKLI	711.1	18. Mother's Name	/Eirst Middle							
anc	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	10 E	JOHN HUTCHISON	,0)										
Maryland 21215-0036	should be file and Mental I is marked of raumatic eve		19a. Informant's Name/Relationship (Type, Print)	State, Zip (	Code)									
Σ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		DONNA DOLINA/GRANDDAUGHTER		BATTEE DE									
Baltimore,	Page 1 al ment of H ant: If itel ury or oth		Burial 2 Cremation 3 Removal from State		sition <i>(Name of</i> natory or other place L CEMETEF	9)	Date /2010	20c. Location SUITLA	-					
를	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) CE  21. Signature of Funeral Service Licensee		HOME									
Ba	Depart Impo any	, i	► Man Inderick	20746										
			est,		Approximate Interval Between									
	Physician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition VALVULAR HE		Onset and Death									
	Medical Examiner		resulting in death) Due to (or as a consec	quence of):				11	/					
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88	ath certifica attending p for use as i	M/m	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fe	nancy	Ectopic pregnanc	v		23d. D	ate of deliv	,				
P.O. Box 687	death	Physician/Me	1 Yes 2 No 4 Pregnant at time o		Other (specify)			M	lonth	Day Year				
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S, D	ires th signe Id be c	d by					1 🗆	Yes 2 🛣 No	3 🗌 Pro	babiy 4 🗆 Unknown				
ord	v requires s been sig should b	Completed					24a. Was		. Were auto	ppsy findings available ompletion of cause of				
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⋛	Physic this c	2	examiner?  1 X Yes  2 No  Hospital:  1 Inpatient 2 [ 27. Manner of Death  28a. Date of injury	ER/Outpatier 28b. Time of		4 🖂 Nursing no		dence 6 Ot		(y)				
0 0	ding l th. : After e funer	cate	1 IX Natural 5 □ Pending (Month, Day, Year) 2 □ Accident Investigation	injury	work		zod. Describe i	ow injury occur	,,,,,					
Division of Vital Records,	er dea ector by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, str	eet, factory, office				ber or Rura	il Route Number,				
<u>S</u>	pspital or A hours after uneral Directed filled in by													
	Hosp 24 ho Fune eted fi	edic	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	29b. Signature and title of certifier		29c. License	number		29d. Date sign	ed (Month,					
	5		· Ostable	*	D19633			11/11/2	010					
	Qn		30. Name and address of person who completed cause of death (It			1A CLINT	ON, MD	20735						
	Sta	JOHN C. PATTERSON, M.D. 7501 SURRATTS RD., #201A CLINTON, MD 20735  State  31. Pate filed (Month, Day, Year)  32. Registrar's Signature												
	Registr													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Day 26 2010 Mark Sherman Thomas Jr 5:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 0 F Hours Mary Tand **Director** 83 06/08/19 168-20-1932 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norfified \*\* once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 United States 7285 D. Coachlight Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 46-47 white Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Army Map Elementary/Seconday (0-12) College (1-4 or 5+) Service <u>Cartographer Engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mark Sherman Thomas, Sr. Eleanor Traver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7285 D. Coachlight Ct., Frederick, MD 21703 Mark Stephen Thomas / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery 12/02/2010 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between The nor Clerofic Immediate Cause (Final Candiovascalan Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 After this certificate has funeral director, page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours area. \_\_\_ To the Funeral Director: After To the Funeral Director: After To the Funeral After To the Funeral Fu 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Kranz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

180

Tohnion

29c. License number

000 35152

29d. Date signed (Month, Day, Year)

Frederick MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 0:50 AM Cullen Anthony WALKER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital 4b, City, Town, or Location of Death Examiner Rockville Montgomery Medical Center 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Nov. 2, 2010 Min. Hours 1 🛛 M 2 🗆 F Days 6 Maryland Director Usual Residence of Decedent or 28a-f show a notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ŏ must be 21740 USA 23a Funeral 838 Frederick Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12 Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black White, etc. "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 Divorced than "nature the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. none the none traumatic event, Be be filed \ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked o Marlaina Walker William Beebe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 838 Frederick Street, Hagerstown, Md. 21740 Marlaina Walker - mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory: 11/10/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service License halit Skulle 21740 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 Physician disease or condition resulting in death) Medical Due to (or as a consequence of): PREMATURIT Examiner Sequentially list conditions, if any, reading to minimediate cause. Enter Underlying Cause (Disease or iinjury transit. and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 the 88 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Dav in the past 12 months? for Pregnant at time of death 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 No page 2 s has this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After a completed filled in by the funera work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Certifying Nurse Practioner/ To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier hination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Dav. Year) 29b Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 99 ROCKVIL 0 MEDI CENTER DRV. AGNES

State

Registrar

egistrar's Signatur

Year 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene me, g911,01/12/2011dhb Certificate of Death Reg. No. Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Day 9 Dianne S. WALTON 7:00 P. November 2010 Medical 4a. Facility Name (if not institution, give street and number)
Washington Adventist Hospital o. City, Town, or Location of Death Takoma Park 4c. County of Death **Examiner** Montgomery 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Days Min. Months Hours 1 ☐ M 2 ☐**X**F 67 Yrs. Director 1943 364-44-7056 <u> Detroit</u> Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Takoma Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be i Funeral 20912 #810 7051 Carroll Ave. U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry Albertson's Super 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Market ashier Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eve Catherine Buttery Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9017 Bradford Rd., Silver Spring, MD Doug Hamby / brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) Metropolitan Crematory Nov. 11,2010 <u>Alexandria, VA</u> 21. Signature of Finer 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed AP OVED BY MEDICAL EXAMINER that initiated events Due to (or as a for resulting in death) Last Physician/Medical Box 68760 CERTIFICA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown P.0. ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco ase contribute to the cause of death? Part II Other significant conditions contribut Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of cate has ; page 2 s performed 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours at er death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case 26. Place of Death (Check only one) **Division of Vital** examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year, 28b. Time of injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at р 5 Pending Natural Subject slipped and fell. Certifical 1 🗆 Yes 2 🛣 No 2 Accident 10/25/2010 **Unknown** M Investigation 6 Could not be 28f. Location (Street and Number of Rural Route Number City or Town, State) 7051 Carroll Ave. #810, Takoma Park, MD 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

7701 Carroll Ave., Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasreen Kango, MD

NOV 12 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Year November РМ Arthur John Whalen, Jr. 4:21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac Manor Care- Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Missouri Days Months Hours Oct 13 1937 1 🌠 M 2 🗆 F Director 487-38-3179 73 Yrs. Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tife if item 275 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 💢 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20882 USA 24617 Woodfield School Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 🗌 Widowed 4 💢 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Attorney Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Anne Steele Arthur John Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Michelle Paris/Daughter 24617 Woodfield School Rd., Gaithersburg MD, 20882 permit. Page 1 and 3 Department of Healf Important: If item 2 any injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 12 2010 Silver Spring, MD Gate of Heaven Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 1= Millian 10 E.Deer Park Drive, Gaithersburg, MD 20877 MO1202 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Cerebral Vascular Accident Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, Examine Due to for as a ponsequence of if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-tre Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 2 No the a 9 Unknown P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No this certificate Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Susan J. Miller, MD,

NOV 1 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

29c. License number

D35579

8218 Wisconsin Avenue #305, Bethesda, MD 20814

29d. Date signed (Month, Day, Year)

November 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:20 P M November 7 2010 Robert T. Wright /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery Wilson Healthcare Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Jan 31 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ★ M 2 □ F 94 Nébraska 220-34-4569 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Modical Examinations to notified at 1 ☐ Yes 2 ☐ No Director Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event once. United States 301 Russell Avenue 20877 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No Specify: Specify: White <u>ک</u> WW II 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Lawyer Judiciary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Grace Miller Robert Roland Wright ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19900 Chesley Knoll Drive, Gaithersburg MD 20879 Robert G. Wright/Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 11 2010 Rockville, MD Parklawn Mem. Park 22. Name and Address of Facility Devol Funeral Home 21. Signature of Funeral Service License |10 E. Deer Park Drive, Gaithersburg MD 20877 MO1116 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Conjective heart ailure Physician disease or condition resulting in death) /Medical Due to ( as a consequence of): Examiner certensive arterioselesation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical the ! use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ξ 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No Recurrent as f 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manyfer of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 8, 2010 I A. Robert Brischbach und. 04115 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELLAUENUE (LRUBERT BIRSCHBALH, MA. GAITHERSBURG, MA 208149) ILRUBERT BIRSCHBACH, UM 32. Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

NOV 0 9 2010

		1	For State Registrar	State of Maryland		tificate of Dea	ith	Reg	g. No. 2 🕦	0	376	659
ř	Physicia	_	1. Decedent's Name (First, Middle, Las Agazit	Woldeab				Nov. 5		ear	3. Time of 3 : 1 5	Death D <sub>M</sub>
)	/Medic Examin		4a. Facility Name (If not institution, give	street and number) hire Avenue#	1120	4b. City, Town, or Locat			4c. County of		ry	
	Funeral Director		5. Social Security Number 6. Se			If Under 1 Year If Un Months Days Hou	Min Min	Date of Birth (Month, Day, 0 / 0 5 / 1	Year)	Count	ace (State o try) trea	or Foreign
Ī	Maryland I-f show fied at		Usual Residence of Decedent  10a. State 10b. County  MD Montgom		Town or Lo	cation a Park					0d. Inside Ci 1	-
	n with the	Funeral Director	10e. Street and Number 7401 New Hamps	hire Ave.#11	20	10f. Zip Code 20912		10	g. Citizen of Wh	SA		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 █ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 <mark>K</mark> No S <i>pe</i>			Specify:	White, 6	etc. lack	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life. i	dent's Usual Occupation kind of work done during DO NOT use retired) Celemetry	nost of working	,	6b. Kind of Busi			
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2	and 2 shou alth and M 127 Is mar er traumat		19a. Informant's Name/Relationship (*Deborah Habtem	ichael/	2131	l Bradley	Street	Maple	ewood, N	linn	esota	117 a
Baltimore,	Pages 1 annent of He ant: If item ury or othe		20a. Method of Disposition			osition (Name of matory or other place) rat Cemete	ery		Asma1	a,E	Critr	
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Light	MC		HPPPPPAdpessR 241 Columb				/ICI		
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.  Acute myoc	Do not en	ter the mode of dying, su al infarct	ch as cardiac or	respiratory arre	est,		Approxima Interval Be Onset and	tte tween Death
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P.O. Box	The law requires that the death certif the has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mor		ery Day	Year
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	ng Phys After this Ineral di	on: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injury at Work?			ow injury occurre		97	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e Place of injury . At ho	me, farm, s			8f. Location (S City or Tow	treet and Numb n, State)	er or Rui	al Route Nu	ımber,
	e Hospital 24 hours a e Funeral letely filled	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea tion and/or	ath occurred at the time, on the stime, on the stigation, in my opinion	date and place, a on, death occurr	and due to the d ed at the time, d	cause(s) and ma date and place,	nner as and due	stated. to the cause	e(s)
	To the within 2	Med	29b. Signature and title of certifier	munc		296. License nu MO 6	mber 20414		Nove		n, Day, Year) r8, 20	
	\ PR		30. Name and address of person who				Wash	DC				
	Si Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa								
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			Registrar  1. Decedent's Name (First, Middle,	Last)		Si tillicate of L		2. Date of Death	, No.	3. Time of Death						
п	Physicia Medic	al I	William Michael	Wilkinson,S	r			November								
1	Examin	Ŭ.	4a. Facility Name (if not institution, Anne Arundel Me	dical Center		Annapo.			4c. County of Dea	ndel						
	Funeral Director		214-44-7690	6. Sex 7. Age	(In yrs. last birthday 4 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 06/07/19	g. Bir 46 Mar	thplace (State or Foreign y Land						
	land f show d at	tor	Usual Residence of Decedent  10a. State 10b. County	A d - 1	10c. City, Town or				10d. Inside City Limits							
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	ith the		130 Gibson Road		10f. Zip Code 21401		'	. Citizen of What Country? United States								
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Maryland	d 2 should alth and M 1 27 is ma ir traumat	10c. State   10c. County   10c. City, Town or Location   10c. State   10c. County   10c. City, Town or Location   10c. Street and Number   10c.														
Baltimore,	e 1 and : of Hei If item or othe		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 ☐ Removal from State	cemetery, c	position (Name of rematory or other place	ce)		c. Location - City o							
tim	it. Pag rtment rtant; njury o		4 Donation 5 Other (S	oecify)		Crematory 22. Name and Addre				Maryland						
Ba	perm Depa Impo any i		21. Signatur Filheral Service Li	thalf												
			2973 Solomons Island Road, Edgewater, MD 21  23a. Rath. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximative and the death of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and													
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			resulting in death) Last	d												
687	ertifica ding pl se as t	/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of de	alivery						
Box 68760	The law requires that the death certificate be attended by the attending physici page 2 should be detached for use as the but	Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown		B	cy		Month	Day Year						
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ds,	requires t been sign should be	ted k						1 🗆 Yes		Probably 4 🗌 Unknown						
of Vital Records,	law re has be je 2 sho	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of						
- B	ician: The la certificate ha rector, page	င္ပ	25. Was case referred to medical			26 P	lace of Death (Chec	1 Yes 2	INO 1 □ Ye	es 2 🗆 No						
Vita	ysician: is certific director,	To B	examiner? 1  Yes 2 No	Hospital:	ent 2 ER/Outpa	Oth	ner.	ome 5 - Residence	ce 6 Other (Spe	cify)						
J of	ding Phys th. After this ( funeral dir		27. Man r of Death 1 Natural 5 ☐ Pending	28d. Describe how	injury occurred											
Division	il or Attendi safter death. I Director: A d in by the fu	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	not be 280 Place of Inju	ry - At home, farm,	M 1 L	Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Ri	ural Route Number,						
Ο̈́	To the Hospital or Attending Physiciam: within 24 hours after death of the Funeral Director. After this certific completed filled in by the funeral director,	Medical Co	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, dea	th occured at the time	e, date and place, a	nd due to the cause	(s) and manner as s	ated.						
	the Ho thin 24 the Fu mplete	Mec	(Check 2 ☐ Medical E only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my knowledg	e, death occurred at the	ne time, date and pla	ice, and due to the ca	ause(s) and manner a d. Date signed <i>(Mon</i>	s stated.						
	<b>5</b> ₩ ₩ 0		Signature and title of certifier	plux D.U.			1048 <u>)</u>	290	II/ W ///	ui, vay, iedij						
a d	1 /		30. Name and address of person v		eath (Item 23a) (Type	e, Print)		^								
	HQ.			Jet 600	1 Fillage	12 Ave	rue f	for a po	II ma	yland.						
	Sta Registr		31. Date filed (Month, Day, Year)	8 2010 32. Registra	r's Signature	backer										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death WALLER Physician/ Month 2010 1140 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arunde1 Annapolis 10 Domino Rd 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days July Day New Jersey 1 M 2 F <sup>(ea</sup>l 936 74 Director 212-34-1824 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho appropriant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amply or other traumatic event, the Medical Examiner must be notified at 10a. State Director Pa. Philadelphia Philadelphia 1 Yes 27 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 19143 USA 5416 Angora Terrace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ş 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: **Black** 3 Divorced 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Board Philadelphia Elementary/Seconday (0-12) College (1-4 or 5+) of Education 4yrs Educator 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Adele Adkins Charles M. Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Md. 21409 Charles M. Walker Jr(Brothet) 1317 Yorktown Rd. 20b Baso Topodio (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Memorial Park 11-10-10 Annapolis, Md. 4 Donation 5 Other (Specify) Wmame Recese of ScilisSons Mortuary, P.A. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Lavy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) ) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed 2 No 1 Yes 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be 151225 Residence Other: 4 Nursing Home 5 Residence 2. No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After injury 1/ Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) EMBER 042010

State Registrar DEFENCE

Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

ICHAEL

NOV 092010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** West River Anne Arundel 1025 Biltmore Ave. 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours New York 6/10/1940 70 **Director** 108-30-0658 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Medical Evaminas more hands and injury or other traumatic event. 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No West River Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 20778 1025 Biltmore Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status vvas Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1958If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced 1963 Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Barbara Jean Bowyer Stuart G. Wilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 Biltmore Ave., West River, MD 20778 Deborah Wilton/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Decremation 3 Removal from State Kalas Crematory 11/9/2010 Edgewater,MD 5 Other (Specify) 4 Donatio 22. Name and Address of Facility George P. Kalas Funeral Home Signature 2 Funeral Service Ligense al 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part . Enter the disease or complications shock, or heart failure. List only one cause Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Seath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other 1 Yes 4 
Nursing Home Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

GHTFOOI-TAYLOR

32. Registrar's Signature

Re. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENEVIEVE

31. Date filed (Month, Day, Year)

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DEFENSE HWY,

5010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician Abbot 30 rie 2010 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner entreville 4nnes Hospice of Social Security Number ucen Hones Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 Months Days Hours Min 559-68-6231 2011910 California Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Centreville Queen Anne's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 Overture Way 21617 USA or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the My Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Darby Nellie Thompson ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter D. Abbott, son 219 Overture Way Centreville, MD20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/01/2010 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (o) as a consequence of): Examiner hemig Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Directo for as a nonsequence on he law requires that the death certificate be executed DOX1 Box 68760x IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 menths?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month Year 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **N**o 2 🗆 No 1 □ Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0067888 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

arow

32. Registrar's Signature

Centrentle Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3. 40 AM MARY C. **AVERY** work Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hincore Homes If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** APRIL 6, 1 M 2 KF Months Director 250-54-1342 SC Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director BALTIMORE 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a 21207 2121 WINDSOR GARDENS LANE USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) TAILOR CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM LONG, SR. MADELINE DRAKE 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 PARK AVE. GLORIA FORREST/DAUGHTER APT 614 BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place ON SITE CREMATORY 12/1/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final Physician/ Lew disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to any cause. Enter Underlying Examiner Directo (or es a consectiones of) Hospital or Attending Physicial. The law equires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has certificate ha performed? Yes 2 No 1 ☐ Yes 2 ☑No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ည 1 npatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 Watural (Month, Day, Year) 5 Pendina 1 Yes 2 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa ure and title of certifier 29c. License number 148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

		-	For State Registrar	State of Ma	ryland		rtment of I tificate of L		nd Mer		gien Reg. N	2010	37665
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$\bigcirc$	Medic Examin		4a. Facility Name (if not institution, give Montgomery Hospic		use		4b. City, Town, o	r Location of D	Death			c. County of Deat	
	uneral irector		5. Social Security Number 6. Se 579–16–4804	X M 2 $\square$ F	(In yrs. last 86	<i>birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Date of Birl		9. Bir 924 Wass	thplace (State or Foreign Mington, D.C.
yland	28a-f show otified at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome		10c. City, 7	Town or Loc	ation Bethesda						10d. Inside City Limits 1 ☐ Yes 2 ♣ No
th the Ma	3a or 28a t be notif	늅	10e. Street and Number 7703 Granada Driv				10f. Zip Code 208	17				Citizen of What Co	Juntry?
laryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mantal Horiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 🖾 Yes 2 🗌 N		If	/as Decedent of H Yes, specify Cuba	an, Mexican, P	? (Specify ' uerto Rica	Yes or No- n, etc.)		14. Race - Ame Black, White	rican Indian,
<b>215-0</b> iin 72 hour	han "natu Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)		- 17	(Give k	ent's Usual Occup ind of work done of NOT use retired)	during most of	f working			Kind of Business	-
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Maryla 2 should b	7 is mark traumatic		19a. Informant's Name/Relationship (Ty Jean D. Altimont/V	pe, Print)		19b. Mailing	g Address (Street of Granada D					or Town, State, Zin	o Code) 0817
nore, I	t: If item 2	1	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 💆 Other (Specify		20b. Plac	ce of Dispos	ition (Name of atory or other place leaven eum	-	ecembe 2010	or 6	20c.	Location - City or	
Baltin permit. Pa	Importan any injury once.		21. Signature of Funeral Service License	ee	<u>і м</u> 00198							Pathon	da-Chevy e Inc. d 20814-3501
Phys	sician/		23a. Part 1/ Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	lications that caused to be cause on each line.		Do not enter	the mode of dyin				_		Approximate Interval Between Onset and Death
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cuted	and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. Due to (or as a									
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Division of Vital Records, P.O. Box 687 fo the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.		Σ	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at t 9  Unknown	☐ Fetal d	leath 3	Ectopic pregnanc Other (specify)	Ç <b>y</b>				23d. Date of del Month	livery Day Year
S, P.O	signed by d be deta	d by Pł	Part II. Other significant conditions co Coronary Artery I	-	not result	ing in the ur	derlying cause giv	ven in Part I.					the cause of death?
<b>ecord</b> e law requ	e has been ge 2 shoul	mplete	Chronic Obstructi	ve Pulmona	ary D	isease	2				osy rmed?	prior to death?	topsy findings available completion of cause of
<b>ital R</b> sician: Th	certificate rector, pa		25. Was case referred to medical	Hospital:			Oth	ace of Death (		- 1			Hospice
n of V nding Phys	After this funeral di	Certificate: To Be	27. Manner of Death  1 🔀 Natural 5 🗆 Pending 2 🗀 Accident Investigation	1 ☐ Inpatier 28a. Date of injury (Month, Day,	28	NOutpatient  Bb. Time of injury	28c. Injury	4 LI Nursii	28d.			6 🖾 Other (Spec iry occurred	ify) HOSPICE
Division all or Atters a after dea	Il Director		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		e, farm, stre	et, factory, office			Location (S City or Tow			ral Route Number,
he Hospit in 24 hour	To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2	Med	(Check 2 Medical Examir only one) 3 Certifying Nurs		mination a	nd/or investig	gation, in my opinio	on, death occur	rred at the t	ime, date a	nd plac	e, and due to the	cause(s) and manner stated
Tot	7 00 V		29b. Signature and title of certifier	melter	C	enp	29c. License R143				29d. D.	ate signed (Month) $129/10$	n, Day, Year)
	1041		30. Name and address of person who co Debrah Miller, CRN				int) i11 Road	, Rockv	ville	, Mar	y1a	nd 2085	5
F	Stat Registra	٠	31. Date filed (Month, Day, Year)	32. Registrar									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** haron PM Souturient 9:06 Nou 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Center Mercy Medical Battinore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1□M 2**X**F Days Hours 216-68-4264 Usual Residence of Decedent March 29, 1956 North Yrs. Director the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Director 286-1 more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or items 23a Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Int: If Item 27 ie marked other then "nature!, or Items 23 on Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Ď Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ebotomist 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant' Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any injury or other treu once. 8 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1/2010 GreenMount 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Fability Funeral 17. Joseph L. Russ 2722 W. North Home 23a. Part 1. Enter the disease, droomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease **Physician** /Medical Examiner ongestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit o the Hospital or Attending Physician: The lew requires that the death certificate be executed Dertension Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760. Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery etter for u 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) sete has been signed by the case 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ∏ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 2XER/Outpatient 3□ DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this To the Funeral Director: After th completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and Alex Mornitier 29c. License number 29d. Date signed (Month, Day, Year) D0060024 ress of person who completed cause of death (Item 23a) (Type, Print) enkel. 301 ST PALL LACE State 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 11:20 PM 29 rovember Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sallstoni Bethinge Cont If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New Jersey Director 135-44-5467 26,1957 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Presque Isle 1X Yes 2 ☐ No Maine Aroostook 10e. Street and Number 10g. Citizen of What Country? Funeral 04769 731 Reach Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 196

If Yes, Give 197 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 ho1969 Black, White, etc. 1 Never Married 2X Married by Maryland 21215-0036 1 ☐ Yes 2X No Specify: 1972 White Completed Specify: 3 Widowed 4 Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mental Hygiene. Mail Carrier Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Merald Edward Baldwin Helen Houser and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 731 Reach Road Presque Isle, Maine 04769 Jacalyn Baldwin, Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/02/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate beath certificate beath. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? After this certificate has been signed by the atter funeral director, page 2 should be detached for Month Pregnant at time of death
Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**X**No Other: မ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di Medical 29a. Certifler Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 3+1 ne and address of person who completed cause of death (Item 23a) (Type, Print) 5401 011 Court rar's Signature 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 410 OW Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death **Examiner** County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 N F Min. (Month, Day, UNKNOWN Director 111101 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Imore ANDALLSTOWA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2113 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married ğ 2 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ø No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) INTANT D Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 2 e151+A row 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KA 10 KANDALLSTOWN - MOTHE 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 0 / 4 Donation 5 DO Other (Specify) Hospital DALMMORP +OSDITAL . Şignature of Funeral Service Licensee DisposAL 2401 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 100 minutes Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events. Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes ∠ ⊭ ☐ Unknown 4 ☐ Pregnant g ☐ Unknown signed by the a ld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed! this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After Natural injury 5 Pending I Director: A 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined ב Puneral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 10/10 30. Name and address of who completed cause of death (Item 23a) (Type, Pript)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 0

OLTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ rown Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Examiner Town, or Location of Death County of Death Himore 0+1 Himore 8. Date of Birth **Funeral** 9. Birthplace (State or Foleign 1 X M 2 □ F Director NKNOW 201 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item. or any injury or other trainment. 10a. State 10b. County Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits moll NDALLSTOW 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 OKAL Was Deceae... Armed Forces? Ves 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2. ☐ No Specify. STACK 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INJANT 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျှ rowx 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kel HA rown 0 ANDALLSTOWN 20a. Method of Disposition 20b. Place of Disposition (Name or or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hospith 0 ALTIMORA 21. Signature of Funeral Service Licensee DISPOSAL 22. Name and Address of Facility SINAI HOSPITAL OF 2401 Belvesere 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciana maturit disease or condition Ominutes Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24 hours after death.

Funeral Director: After this certificate has been a Funeral Director. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes 2 ANO Other: ြု 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practiong: 16 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier address of person who co mpleted c 21215 1) A LTIMOR istrar's Signat State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 37670 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $25^{\text{Day}}$ 2010 Jean Broom 12:32pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Baltimore Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days Hours Director 2-46-9164 Dec. 29, 194 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Collinsdale Rd 21234 usa 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. Black Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Balto City Public Instructional SupportTea 6yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Russell Theresa Whitehurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Broom/Daughter 6727 Collinsdale Rd Parkville Md 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 2,2010 Parkwood Cem. Balto, Md. 4 Donation 5 Other (Specify) Dec. 21. Signature of Funeral Arvice Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 F. PRESTON ST. BALTO MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC COLON CANCEK disease or condition YEARS Medical resulting in death) Due to (or as a consequence of): Examiner AND METASTASIS LUNG MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day rate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION DIABETES MALN UTRITION 1 Tes 2 No 3 Probably 4 Niknown Completed DYSLIPIDE MIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) TN PATIEN Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 No 2 Accident
3 Suicide completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Tatima Ahi MD DOD 69962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

DEC 0 2 2010

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DHMH 17 Rev 7/2009

GILCHRIST INPATIENT UNIT, 555 W, TOWSON BLI. 20204

NAQVI

MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:05 P. M November 25 Theresa Beksinski Medical 4a. Facility Name (if not institution, give street and number)
2418 Pelham Avenue 4b. City, Town, or Location of Death Baltimore 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 216-24-8627 1 □ M 2 🕱 F Months Days November 197 Mary Yand 1928 Yrs **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A Maryland Baltimore 1 ★ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2418 Pelham Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Teledyne Industry Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Peter Helowicz Anna Bodgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Weathervane Rd. Baltimore, Md. 21234 <u>Cecelia T. Stefanowicz-Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-30-2010 Holy Rosary Baltimore Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Leonard J. Ruck Faciling. 5305 Harford Road Baltimore Maryland 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
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4 Homicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral C Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 20

Registrar DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Year **James** Belcher :16P M Medical November 29,201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Greater Baltimore Medical</u> Cente Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min (Month, Day, **Director** 213-94-5375 Yrs. 19,1966 Maryland Usual Residence of Decedent 28a-f sho 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3116 Shortway 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after or Health and Mental Hydiene. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. White Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 9 years Customer Service Manager Home Builders Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James H. Belcher Mary Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Health al Important: If item 27 is Mary Belcher mother 3116 Shortway, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of December 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Durial 2 Dremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2010 Sign ture of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. thou 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sinonasas cancer disease or condition 8 months Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death i signed by the and to be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performed? Yes 2 No 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 \( \subseteq \text{Yes} 2 🗌 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a);(Type, Print) 21204 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day CONNIE BOWENS 10:47 P M NOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CENTER JOHNS HODGEN BANTEN MEDICAL BALTIMURE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye August 28, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏻 F Months Davs Hours 212-46-0595 Director 64 Virginia Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Baltimore Maryland Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 South Marlyn Avenue 21221 Apt 2A USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", 3 X Widowed 4 □ Divorced Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Barmaid Restaurant Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thrent of Health and Mental Hyrant: If item 27 is marked oth jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Clyde Robertson Pauline Mamie Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 St. John Street Apt A, Havre DeGrace, MD. 21206 Jamie Rapp Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. XBurial 2 Cremation 3 Removal from State December permit. Page Department of Important: If any injury or Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 1, 2010 Signature of Fune I Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, or complications that caused the death. On the enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Interval Between Immediate Cause (Final Onset and Death Physician PNEUMUNEA disease or condition resulting in death) 10 DAYS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director: At completed filled in by the ft. ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) RES-600 26,2010 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARC LAROCHELLE M.D 4940 EASTERN AVENUE BALTIMORE MD 21224 31. Date filed (Month, Day, Year) **DEC 0 2 2010** 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Marylar		artment o			d Mer		giene Reg. No.	0	37674
	4 30 00	u	1. Decedent's Name (Fin	rst, Middle, Las	st)							Date of Dea Month	ath Day	.Year	3. Time of Death
	Physicia /Medic		Drewie		Micha	el	В	utcher					FE	2010	2324PM
	Examin		4a. Facility Name (If not	institution, give	street and nu	mber)		4b. City, To	wn, or L	ocation of De	eath	•	4c. Coun	ty of Death	
			Franklin So	luare t	Osontal	Conte	2	Rosa	tale	7			Balt	1 mor	e
	Funeral		5. Social Security Number	er 6. S		7. Age (In yrs.		If Under 1 Months [	Year Days	Hours N	Irs. 8.	Date of Birt (Month, Da	h v, Year)	9. Birth	place (State or Foreign
	Director		216-52-4436	)	A) M ZUF	5	9 Yrs.				Ąŗ	Month, Da Iril 12	1951	Mary	land
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	with ti	Dir	10e. Street and Number 944 Barron					10f. Zip C	2122	21			US		nuy?
	s 23e	by Funeral Director				edent Ever in U	15 13				(Specify	Yes or No		ace - Ameri	can Indian.
	after dea or items	ü	11. Marital Status 1 □ Never Married	<b>%</b> Married	Armed Fo	orces?		Was Deceder If Yes, specify	/ Cuban	Mexican, Pu	erto Ric	an, etc.)	В	ack, White,	
36	irs af	by F	3 ☐ Widowed 4 ☐		If Yes, Gi Year or D	ve		1 ☐ Yes 2 ☐	XNo	Specify:			Spec	iiyWhit	e
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butcher, Drewie more Maryland 21215-1	ges 1 and 2 should be filed within 72 hours after death with the Maryla if of Heatth and Menhall Hygiene and the filed than 23s or 28s-1 ehou or other traumstic event, it a Meulcal Examinar must be notified at		19a. Informant's Name/	Relationship (	**								er, City or Tow		c Code)
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3	M ite	1	20a. Method of Disposit 1 ☐ Burial 2 ☐ Žr		Removal from	State	Place of Dispo cemetery, cre			De	cemb		20c. Locatio		Maryland
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Baltimore Maryland 21215-0036	permil. Pages Department of Important: If i any injury or once.		21. Signature of Funda	Jul	N		7	7110 Sc	İleı	rs Poi	nt R	oad, I	Oundall Oundall	P.A.	21222
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	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after deeth.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edicai	29a. Certifier 1 (Check only one)	Certifying Pl	miner: On the	e best of my kn basis of examin nnescated.	owledge, dea ation and/or i	th occurred at nvestigation, is	t the time	e, date and p nion, death o	lace, and occurred	d due to the at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
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			30. Name and address	of person who	completed cau	ise of death (Ite	m 23a) (Type						1.10	1	/
15			DR. Rachel	Malla	lieu.90	200 FRO	nklin		e Dr	PIVE F	Saltir	nage.	MDala	37	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 19 7:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. **Director** Isual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21216 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces? Mexican, Puerto Rican, etc. Yes, specify Cuban Black, White, etc. 1 Neyer Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 ₩Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16h Kind of Business Industry opcky (0-12) ife. DO NOT use retired) Elementary/Sec College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ည 105C a -arrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 timore MD 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen Greene Funeral hn MDZIZZ9 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ 1a Month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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State Registrar DEC 0 2 2010

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/18/2010 Wolfgang Czubba Physician/ Sean 12:24am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Tacoma Park MD Montgomery Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Germany **1**√2 M 2 □ F 33 Months (Month, Day, Year) 153-80-3216 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director DC District of Columbia Washington DC 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1839-9 St. NW 20001 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black White etc. 1XXNever Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: white If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mee Elementary/Seconday (0-12) College (1-4 or 5+) Computer Science Computer 12 2 Be 17. Father's Name (First, Middle, Last)
Fred Czubba 18. Mother's Name (First, Middle, Maiden Surname) Charlene Peterson ည 19a. Informant's Name/Relationship (*Type, Prir* Fred Czubba / Father 19b Mailing Address (Street and Number or Pural Boute Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial XX Cremation 3 Removal from State Ardent Crematory or other place) 11/24/2010 Hanover Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility CHarles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Peath 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Hatural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Quertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) M D006011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 531 BLVD 2-sist MO Silvershy 2-205 31. Date filed (Month), Day, Year)

DEC 0 2 2010 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 3perPHYS, G910, 12/7/2010 WS
State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **9: 10 P** Physician/ 25, 2010 November Paul Basil Campbell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Halethorpe 1106 Raven Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months Days Hours April Day 9 ear) 192 1 XM 2 - F Maryland 85 Director 220-12-7362 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Director 1 🗆 Yes 2X No Halethorpe MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21227 United States 1106 Raven Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed Army 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Co. Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Nora Agnes Fleck John Joseph Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Raven Drive, Halethorpe, MD 21227 Geraldine Campbell - Wife 20b. Place of Disposition (Name of MDCeVery Crains of Cemere ry 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11-30-2010 4 □ Dob Garrison Forest
22. Name and Address Owings Mills, MD @ on 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Si a well f uneral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Reins disease or condition Medical resulting in death) Examiner pertusian Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Line, Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 Other (specify) the hed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detack. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🔊 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner: Other: 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home မ 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature a dress of p on who completed cause of death (Item 23a) (Type, Print) 30. Name and Drest Qual ) Baltimore 32. Registrar's State Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Amend 10e, per Fn G910 12/2/10 TT State of Maryland / Department of Health and Mental Hygiene  1 - State of Maryland / Department of Death  Certificate of Death  Reg. No. (1) (3) 37678																
			<ul><li>State</li><li>Registrar</li></ul>				_	Ce	rtifica	te of L	Death		Reg. No	<u>: U I</u>	U	3/0/8	
	Physicia Medic		1. Decedent's Name	(First, Middle Chann		JR.						2. Date of De Month Novemb	Day	y 2	Year 010	3. Time of Death	
ar brong.	Examin		4a. Facility Name (if		_		.1.0	/		, Town, or	Location of Death	1	4c.	. County o	f Death		
e sand	Funeral		Johns Hoy 5. Social Security No.		6. Sex	7. Ag		ast birthday)	If Und	er 1 Year	If Under 24 Hrs.		rth			place (State or Foreign	
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	and show	٦	Usual Residence of 10a. State	10b. County				y, Town or Lo								0d. Inside City Limits	
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	with the 23a or ust be n	Funeral Director	10e. Street and NW 2842 No.	athani thani	el <del>iel</del>	- Way				ip Code 2121	9		10g. Cit	Citizen of What Country?			
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1  Never Marri 3  Widowed			2. Was Decedent Armed Forces? 1 1/4 es 2 1/15 If Yes, Give Year or Dates.	No		If Yes, sp	ecify Cuba	ispanic Origin? (Sp in, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: White			
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pu	e filed trail Hygeled of the event,	To Be	17. Father's Name (								18. Mother's Nar			Surname)			
Maryland	ould be nd Men marke matic		Paul Cha					19h Maili	ina Addre	ss (Street	Mary E and Number or Ru			Town, Sta	ate. Zip (	Code)	
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nore	20b. Place   20b.								Disposition (Name of y, crematory or other place)  Date 20c. Location - City or Town, State greatery 12-1-10 Glen Burnie, MD								
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Fur				1:10	2	2. Name	and Addre		adley-	Ash	ton	Fun	eral Home	
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-	Medical Examiner		resulting in death)		ſ	Due to (or as	a consequ	uence of):					I	DISCH	1		
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	236	c. If yes, outcome 1  Live Birth 4  Pregnant	2 Feta	aldeath 3	☐ Ectopi ☐ Other (		су			23d. Date Mont		ery Day Year	
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o uo	adh. rr. After ne funer	Certificate:	1 Natural 2 Accident	5 Pendi	gation	(Month, Da	ay, Year)	injury	M	worl		Zod. Describe	riow injui	y occurred			
Divisi	3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a									ory, office			(Street an own, State		r or Rura	l Route Number,	
	e Hospi 124 hou e Funer leted fill	Medical		Medical I	xamine	r: On the basis of	examinatio	n and/or inve	stigation,	n my opini	e, date and place, a on, death occurred ne time, date and pl	at the time, date	and place	e, and due	to the ca	use(s) and manner stated.	
	To th within To th comp	2	29b. Signature and		r			3 %		9c. Licens	e number		29d. Da	ate signed	(Month,	Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 Month Physician/ 11:43 Ам NOV MARON Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/(enter TIMORE 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex Funeral 1 🗆 M 2 🔀 F Days Hours Min 0977671960 Maryland 50 Yrs Director 213-78-4710 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland **Funeral Director** 1 X Yes 2 No Baltimore N/AMD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 224 S. Carey St 21223 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. College (1-4 or 5+) Elementary/Seconday (0-12) unk Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leroy A. Collins Auratta Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carey St., Baltimore, MD 21223 31 Shavon D. Porter(daughter) S. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Joseph Crematory or other place. And Crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD 102/10 Signature of Furieral Service Licensee <sup>2</sup>Joseph Adors of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Abl disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner In kno ANASTO MO Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Luknown STA TIC and the burial-trar Due to (or as a consequence of): resulting in death) Last signed by the attending physician Records, P.O. Box 68760 38 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death page 2 should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Yunknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: 2 **V** No 2 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🗆 3 🔲 (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 1306009766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) greene 21201 Nounce Montos 22 525h

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 195 at per Thursday Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OLBE Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 4014 Bonner Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Social Security Number 6. Sex 1 🗆 M 2 🖾 F Days Months Hours Min. 0876377906 Maryland Director 212-24-8266 104 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21216 U.S.A. 2412 W. Lanvate St. 12. Was Decedent Ever in U.S.
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If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic(custodian) Baltimore City 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Butler Bernard Colbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2412 W. <del>Lanvate</del> St.,Baltimore,MD 21216 Jean Curtis 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Joseph Brown FM And Crematory 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/01/16 4 Donation 5 Other (Specify) Baltimore, MD Joseph Address of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Physician/Medical Examiner Day to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events after death.

Director: After this certificate has been signed by the attending physician and is in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 욘 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined within 24 hours a To the Funeral C Medical 1 👺 Certifying Physician: To,the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier pe and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 2610 Month 8: IDAM Physician/ amile ornell Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist HOSPICE OWSOY If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) CT 12 1949 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Hours Min MD Director Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State filed within 72 hours after death with the Maryland Director Baltimore 1 Yes 2 No Windsor Mil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ral", or items 23a o Examiner must be Funeral USA Northmont Was Decede... Armed Forces? Ves 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Black Specify: "natural" 3 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mental ttealth Nurses Aide 12th grade VECLY Be Department of Health and Mental His Important: If item 27 is marked ortany in yor other \*\*\* 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sellars ည Sam Don tanie Duise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruad Windsor Mill, MD 21244 Sharon R. Dow 3302 Northmont 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

GVENMOUNT CILINATORY 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, ND 1203 Vaugnin C. Greene Fuheral sources Signature of Funeral Service Licenses Pandallotown MD 211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Road Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner VET DIGERSP Sequentially list acroditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death ed by the a detached f Unknown g Unknown Division of Vital Records, P.O. page 2 should be detach ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 25. Was case referred to medica 26. Place of Death (Check only one) Hospital or Attending Physician: Be Hospital: Other: 4 \(\text{\text{Nursing Home}}\) 5 \(\text{\text{Residence}}\) 6 \(\text{\text{Other}}\) Other (Specify) \(\text{Hospice}\) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? injury 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) only 29b. Signatu and title of

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

02

32. Registrar's Signature

0007(287

uite 4105, Baltimore, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Ma Registrar	aryland / Depa <i>Cer</i>	artment of He rtificate of De			ene J. No.?	37682
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Clemmia Dooli	n			2. Date of Death Month		3. Time of Death
<b>.</b>	Medic Examin		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice		4b. City, Town, or L	ocation of Death	11/2/	4c. County of Dea	2:35pmM
	Funeral Director		5. Social Security Number 215–16–6825   6. Sex 1 □ M 2 🖾 F   7. Age	e (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 7/26/1	9. Bi	rthplace (State or Foreign ountry)
	nd how at	ř	Usual Residence of Decedent  10a, State  10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Marylar 28a-f sl otified	Director	MD	,	Baltin	nore			XX Yes 2 □ No
	s 23a or 3	Funeral D	10e. Street and Number 7427 Blevins Avenue		10f. Zip Code <b>21</b> 2	219	100	g. Citizen of What C	ountry? USA
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Department of Heath and Mental Hygiene.  Spariorath: If the ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3XXWidowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes 2 □ XIII Yes, Give Year or Dates.	<b>N</b> 6	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 <b>XX</b> o	, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	within 72 hou giene. e <b>r than "natu</b> the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5-	(Give	dent's Usual Occupat kind of work done du O NOT use retired) <b>clerk</b>	ion ring most of workir	ng 16	Sb. Kind of Business Universi	,
/land	d be filed v Aental Hyg arked othe tiic event,	To Be	17. Father's Name (First, Middle, Last) Orlando Pond				(First, Middle, Mai Lind Sm.		
, Mary	nd 2 should ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Naomi Randolph / Daughter		ng Address (Street an 7 Blevins				ip Code)
Baltimore, Maryland	Page 1 ar nent of He ant; If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Calvary	osition (Name of matory or other place) Cemetery	. : -	5/2010 20	oc. Location - City o	
Balt	permit. Departi Import any inji		2 Signature of Fundal Service Licensee Victor	Doda 2	Name and Address haries L. 501 East 1	Stevens Fort Aver	Funeral nue, Balt	Home, Inc imore MD	21230
~- <b>F</b>	hysician	0.3	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	the death. Do not enter.		such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner			a consequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events c.	a consequence of):					
09	cate be executed physician and the burial-transit	edical Ex	resulting in death) Last  Due to (or as a consequence of):  d.						
. Box 687(	ath certific attending for use as	F FEMALE:						23d. Date of de Month	elivery Day Year
ls, P.O.	requires that the de been signed by the a should be detached	by	Part II. Other significant conditions contributing to death but CONGESTIVE HEARS			n in Part I.			o the cause of death?  Probably 4 Unknown
Records, P.	The law red cate has bee page 2 shot	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
/ita	sician: The certificate lirector, pag	To Be (	25. Was case referred to dical examiner?  1  Yes 2 No Hospital: 1   Inputio	ent 2 🗆 ER/Outpatier	Other	ce of Death (Check		ce 6 Other (Spe	1+OSTICE
Division of Vital	b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director, is	Certificate: T	27. Manner of Death  1 Matural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day)	y 28b. Time of	28c. Injury a work?		28d. Describe how		City
Divisi	tal or Atters after de al Directo ed in by the		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm, stre . (Specify)	eet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	To the Hospital or vithin 24 hours after To the Funeral Directory completed filled in the	Medical	29a. Certifier (Check 2 Medical Examiner: On the basts of exonly one) 3 Certifying Nurse Practioner: To the basts of exonly one	camination and/or invest	tigation, in my opinion	, death occurred at	the time, date and p	place, and due to the	cause(s) and manner stated.
	70 th withi Com		29b. Signature and title of certifier	UND	29c, License r	5 /- 000 00		Date signed (Monitory)	> '20 63
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	ONETH Cit.	ARLASS	TREET BY	UTIMORE	MO21204
25	Stat Registra		31. Date filed (Month, Day, Year) 32. Registra	s Signature	parker				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH,G910,12/13/2010,WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) D'Elia Month 11/27/10 Physician/ Eleanor 3:19amм Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice **Examiner** Baltimore Towson 7. Age (In yrs, last birthday) 92 yrs 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** (Moath/25/1918 Days Hours Min Country) 168-52-4056 1 □ M 2**XX** PA **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a, State with the Maryland at Director Towson 1 Yes 2 No notified Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 USA Funeral 21204 555 W. Towsontown Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: white 3 XWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Ò 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Notta Philomena ပ Degillio Vito 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zio Code) 222 Cartland Way, Forest Hill MD 21050 19a. Informant's Name/Relationship (Type, Print)
Robin Konecke /Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 12/1/10 cemetery, crematory or other place).
Mountain View Cemetery 1 Burial 2 Cremation 3 X Removal from State Harding 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home 1501 E. Fort Ave., Baltimore MD Victor Doda ture of Tunical 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 100 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No cate has 1 ☐ Yes 2 ☐ No After this certificate funeral director, pag 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 2 🔀 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certificate: 1 ► Natural 2 □ Accident 3 □ Suicide 5 Pending the Funeral Director: Aft 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier 2010 27 MD D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATH KUMAR 32. Redistrar's Signature 31, Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20 10 7:35 Рм November Robert Eldon Doty, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg 232 Perrywinkle Lane 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Hours Min Months 1 XM 2 □ F December Director 74 050-30-1650 Usual Residence of Decedent or 28a-f shown notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number ō ems 23a or r must be r Funeral 232 Perrywinkle Lane 20878 United States items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 2 □ No 1954-1 Never Married 2 Married o, þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural" 1984 Completed 3 Widowed 4 Divorced Year or Dates is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Military Officer United States Air Force Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ္ Pearl Mae Simunds Robert Edgar Doty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 232 Perrywinkle Lane, Gaithersburg, Maryland 20878 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Sue Anne Doty/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date December 3, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All Souls Cemetery 2010 Germantown, Maryland Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, MD 20850 21. Signature of Funeral Service Licen Houan M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Years Immediate Cause (Final Priyaician/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 以 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Emphysema 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy perform death? performed?

1 Yes 2 X No his certificate hil director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

he Funeral Director: After the Funeral Director: After the maleted filled in by the funeral

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29a, Certifie

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only one

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30. Name and add ess of person who completed ca

Aylesworth

Registrar

DHMH 17 Rev 7/2009

se of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D54378

2730 University Blvd. W. #400, Wheaton, Maryland 20902

29d. Date signed (Month, Day, Year) November 30, 2010

29c, License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nov. 30 2010 Physician/ Davies D. Ruth Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Center If Under 24 Hrs 8. Date of Birth If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days July 8, 1920 1 M 2 XF Hours Min. Pennsylvania Yrs. Director 203-12-5127 Usual Residence of Decedent should be filed within 72 mous and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 23a or 28a-f show it is marked other than "must be notified at 10a. State 10b. County 10c. City, Town or Location Director Glen Arm Md. Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21057 11630 Glen Arm Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Defense Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ൧ Ruth Kennedy Dickson Kenneth 1 and 2 should the of Health and Me. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Maryland 21403 182 W. Lake Dr. Kathleen Page/Friend 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 s
Department of F
Important: If ite
any injury or ott cemetery, crematory or other place) 1 Dunial 2 🔀 Cremation 3 D Removal from State Towson, Maryland Hilltop Service Corp. 12/1/10 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licens 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Cancer with a. LUNA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ Live Birth 2 L Fetal dea in the past 12 months? Month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown Records, 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of death? page 2 s After this certificate 1 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) the Hospital or Attending Physician: director, Be examiner? Hospital: 2 🗷 No ု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 U Suicide 4 Homicide determined Medical 29a. Certifier 29b. Signature and title of certifie

10:10

9. Birthplace (State or Foreign

White

Approximate Interval Between Onset and Death

manth

2 No

USA

10d. Inside City Limits

1 Tyes 2 No

Ам

the Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) K125808 Lewis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar State Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edwin L. Emkey, Sr. M271/2010 Physician/ 7:13 arts Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 406 Theresa Avenue Essex Baltimore 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M 2 D F Months Davs Hours Min. (Month, Day, Year) 8/4/42 217-38-3416 68 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Landsdowne 1 Yes 2 XXo 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number ÜSA 109 Third Avenue 21227 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Food Retail Elementary/Seconday (0-12) Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Christion Margaret Affuth Emkey 19a. Informant's Name/Relationship (Type, Print)
Etta M. Emkey / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 109 Third Avenue, Landsdowne Maryland 21227 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gardens Of Faith Cemetery Department o Important: If any injury or injury or 12/6/2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD Doda )IW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Ta Sa month 力( disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 K No death? 1 ☐ Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be Daughters House examiner? Other: 4 Nursing Home 5 Residence P 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 1 X Natural 5 Pending 2 🗌 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1XXcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifier

30. Name

31. Date filed (Month)

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Elliott November 29, 2010 Stuart Gary Physician/ 4:10 10M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Ravenwood Nursing Home & Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Months Days Hours 1 🙀 M 2 🗆 F 57 370-58-6550 Yrs 06/08/1953 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a, State "natural", or items 23a or 28a-f sho Director Baltimore 1 XYes 2 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21201 Funeral 501 West Franklin Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married Yes 2 No þ within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Information Security Technician 12 1 and 2 should be filed w of Health and Mental Hygi item 27 is marked othe Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen J. McMillan Elliott ပ Lenwood W. 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code)  ${ t r 6036\ t Prospector\ t Dr.,\ t Cadillac,\ t MI }$ 19a. Informant's Name/Relationship (Type, Print) Lenwood C. Elliott Brother other 1 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition rinal Journey crematory or other place) ₫ <u>=</u> ☐ Burial 2x Cremation 3 ☐ Removal from State Woodbine, MD 12/1/2010 ō Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Liver Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Rectal Carcinoma wiht Metastases to Liver **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicial prectors. Box 68760 as the If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) IF FEMALE: 23d. Date of delivery nse 23b. Was decedent pregnant Month Day Year in the past 12 months? þ Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Unknown Massive Ascites, Pulmonary Embolus Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🗌 Yes 2 🗆 No Yes 2X No 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Μ Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier s of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles O'Donovan Evans 2010 12:15A M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Sparks 1120 Belfast Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Funeral Days Min. 1 **X** M 2  $\square$  F Months Hours 1176/1930 Mary Tand Director 213-30-2194 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10b. County Director 1 🗌 Yes 2 🙀 No <u>Baltimore</u> Sparks Maryland| 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21152 1120 Belfast Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education <u>Teacher</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor O'Donovan Henry C. Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 321 South Wind Road Towson, Maryland 21204 John G. <u>Evans / Brother</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition New Cathedral Cem. Burial 2 Cremation 3 Removal from State 11/30/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Faneral Service Licensee Towson, Maryland 21204 1050 York 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list condulons, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Renary Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

Gino

31. Date filed (Month, Day, Year)

32. Registrar's Signatu

N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death  $NO^{\text{poth}}$ Physician/ 2010 Steven W. Frock 9:22 Αм Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 30, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 X M 2 □ F Months Days Hours Min. Maryland 219-56-3453 1951 59 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10a. State 10c, City, Town or Location death with the Maryland Director 1 Tes 2 X No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 þ an "natural", or items 23a Medical Examiner must b Funeral 21221 USA 5 Brett Court, Apt. 101 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) a.m. 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 N. Frock Doris Paul NOVEMBER 27, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Apt. 101 Doris N. Frock, mother Brett Court, Essex, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 12/01/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD George MacNabb 22. Name and Address of Facility Cremation Society of MD, 21. Signature of Funeral Service Licensee Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE LIVER DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Records, Completed page 2 should FROCK 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 🗌 Yes 2 🗆 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2010 3 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD TIMONIUM, MD 21093

Registrar

DHMH 17 Rev 7/2009

State

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	1 - For Amend Items 25 2, 25	Masyland / Department of 1/00th 2016 ( Certificate of Death	Approximate Hygiene Reg. No.2 0 1 0 3 7 6 9 0
			Decedent's Name (First, Middle, Last)		Date of Death     3. Time of Death
	Physicia Medic		Francis	Farley	Month Day Year Nov 18 ao 10 810 AM
	Examin	er	4a. Facility Name (if not institution, give street and number	4b. City, Town, or Location of Death	4c. County of Death
* ***	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
	Director		215-44-3370 1×M20F	86 Yrs. Months Days Hours Min.	Month, Day, Year) 924 Country) NJ
	d now	Ļ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	arylan ta-fsk ified	Director	MD Montgomery	Silver Sox	1 Xes 2 No
	or 28	اقًا	10e. Street and Number	PPt. BC 10f. Zip Code	10g. Citizen of What Country?
	n with	Funeral	3126 Coracefield	NO 00904	USA
	r death		11. Marital Status  1 □ Never Married 2 Married  12. Was Deceder Armed Force 1 □ Yes 2	s? If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.
036	within 72 hours after death with the Maryland jiene. tran "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ed by	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates	1 ☐ Yes 2 ♣No Specify:	Specify: White
2-0	2 hour "natu	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Business Industry
21215-0036	within 7; giene. ner than t, the Me	Completed	Elementary/Seconday (0-12) College (1-4 c	or 5+) life. DO NOT use retired)	Francerina
	Hyg othe	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Sur <u>nam</u> e)
/lan	~ a m ≈	잍	Francis J. I	-arley Anno	C. tarley
Maryland	and sud		19a. Informant's Name/Relationship (Type, Print)	196. Mailing Address (Street and Number or Bura	nl Route Number, City or Town, State, Zip Cofe)
	and 2 s Health s Item 27 i		20a, Method of Disposition	20b. Place of Disposition (Name of	Date UNK 20c. Location - City or Town, State
nor			1 Bunal 2 Cremation 3 Removal from St. Donation 5 Other (Specify)		JOSSUD, PA
Baltimore,	permit. Page Department Important: I any injury o		21. Signature Service Licensee	22. Name and Address of Facility	1 32336717
<u>m</u>			If found I have	M ITAM 1232 M	idvalley Dr. Jessup, HA
			shock, or leart failure. List only one cause on each		or respiratory arrest, Approximate Interval Between Onset and Death
	nysician/ Medical		disease of condition	ricular Arrhythmia as a consequence of):	Children and Details
-	Examiner		Ather	rosclerotic Cardiovascular Dia	sease yearly
		iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	eo a concequence of j:	
	cuted and transi	Examine	Cause (Disease or linjury that initiated events c.	as a consequence of):	
	ate be executed ohysician and the burial-transit	dical E	resulting in death) Last Due to (or	as a consequence sin	
3760	ficate I g phys	/edi	a		
× 687	death certificat he attending ph ed for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcol 1 ☐ Live Bir	me of pregnancy th 2	23d. Date of delivery
Вох	9 9 G	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnal 9 ☐ Unknown 9 ☐ Unknown	nt at time of death 5 $\square$ Other (specify) vn	Month Day Year
P.O.	<b>Physician:</b> The law requires that the des this certificate has been signed by the z ral director, page 2 should be detached t		Part II. Other significant conditions contributing to deat	th but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
S, F	v requires that s been signed t should be det	ed by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown
Records,	aw req as bee 2 shou	Completed			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
Rec	The Is	Con			performed? death? 1 Yes 2 No 1 Yes 2 No
ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	26. Place of Death (Check	
of Vital	g Physer this eral di	e: 10	27. Manner of Death 28a. Date of	injury 28b. Time of 28c. Injury at	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
on	Attending ar death. ector: After by the fune	ficat	2 Accident Investigation	Day, Year) injury work?  M 1 □ Yes 2 □ No	
Division	or Atta after de Directu in by t	Certificate:		Injury - At home, farm, street, factory, office etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ξ	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director. After thi completed filled in by the funeral		29a. Certifier 1 **Certifying Physician: To the bes	t of my knowledge, death occured at the time, date and place, an	nd due to the cause(s) and manner as stated.
	the Hos hin 24 h the Fur mpleted	Medical	only one) 3 Certifying Nurse Practioner: To	of examination and/or investigation, in my opinion, death occurred at the best of my knowledge, death occurred at the time, date and plac	t the time, date and place, and due to the cause(s) and manner stated. se, and due to the cause(s) and manner as stated.
_	With Co		29b. Signature and title of certifier	29c. License number <b>D24035</b>	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of		1 11/19/10
			Eugenio Machado, MD, 3	110 Gracefield Road, Silver S	pring, MD 20904
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 2 2010	istrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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4	U	A. P. Commercial Comme	U	3	1	O	7

		1- For State Certificate Registrar	of Death	Reg. No	D.	0 1 0 2 1
Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day  November 22,		3. Time of Death 1136 hrs
Medical Exami	ner	Javid M. Fritzges  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1100 1113
		8646 Rock Oak Road	Parkville	I	Baltimore Cour	nty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	<b>-</b>	Cou	place (State or Foreign htry)
Director			rs.	Jan. 10,	1954 Ma	ryland
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
	٦	MD Baltimore Balti	MORE			1 Yes 2 No
te Maryland or 28a-f show fied at once.	ect	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Count	ry?
th the ]		8646 Rock Oak Road	21234		USA	
Figure 1 and 2 should be filed within 72 hours after death with the Maryland men to Fleath and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	1 Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
fter de		1 Yes 2 No 3 Widowed 4 N Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify: //	te
nours a	ed by	during	ent's Usual Occupation (Give kind of w most of working life. DO NOT use retir		Kind of Business/In	dustry
36 in 72 h	plet	Elementary/Secondary (0-12) College (1-4 or 5+)			Secure L	Suctions
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maide	n Surname)	243/27113
215 be file mtal H irked ent, ti		19a. Informant's Name/Relationship (Type, Print ) 19b. Mail	ing Address (Street and Number or R			
ID 21 should and Me 7 is ma	٩					
re, MD 1 and 2 sho Health and fitem 27 is		E) Fr 1 + z ges - ON 1,3/1 20a. Method of Disposition 20b. Place of Disp	Z Manning Way osition (Name of cemetery,	Date 20c	Location - City or T	own, State
nore ages 1 nt of F		1 Burial 2 X Cremation 3 Removal from State crematory or	,	20/10	2/2 1/2 1/2 211	mx
Baltimore, ME permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traums.	1	4 Donation 5 Other Specify: 14 Flant 1 21. Signature of Funeral Service Licensee 22	C Crematory 11/6. Name and Address of F cility	adley -17	SK fON FU	veral
m F P m		That the	ome , PA , 2134.	W, 1/0W.	SSKING 1	Road 21222
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line. Chronic obstruct	ive pulmonary dis	respiratory arrest, st ease compl	licated	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. by narcotic intoxic  Due to (or as a consequence of):	ation			Deatt
		Sequentially list conditions, b				
	jne	if any, leading to immediate cause. Enter Underlying Cause c. Enter Underlying Cause c.				
sit id	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				8 /
tox 68760, leath certificate be executed e attending physician and for use as the burial - transit	edical	d.  X UNPENDED X AMENDED 8 9 232 27	20 f non EII/ME	CO10 12/7	/10 тт	
60, ate be shysicie	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	28a-f, per FH/ME		3d. Date of delivery	
certific		past 12 months?	Fetal death 3 Ectopic pregnar	псу	Month Da	y Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 9 Unknown	Other (Specify)			
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		o use contribute to th	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that th rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	ed by				No 3Proba	
ord aw req	Completed			24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
Reco	5		40.0	1 ✓ Yes 2	No 1 Yes	2 No
/ital sician: is certi	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatie	26 Place of Death (Check of Death )		dence 6 🗸 Other:	Scene
of V ng Phy	٩	1 Yes 2 No Imparent 2 Ervoupare 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of		28d. Describe how in		
ion itendir leath. for: A	aţio	Natural 5 Pending Pending Fd 11/22/10 FD 11	15 am	unk		
ivisior or Attend after death Director:	Certification:	3 Suicide 6 X Could not be 28e Place of Injury - At home, farm, str	reet, factory, office building, etc.	28f. Location (Street or Town, State)	and Number or Rura 3646 Rock	oak Rd
Divi		29a. Certifier				
o the Fithin 2.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
\$ 4 £ 4	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Mont	
		Carol Hallar	O.C.M.E.	No	vember 24, 201	0
		Name and address of person who completed cause of death (Item 23a)     Carol Allan, MD	Street, Baltimore. MD 21201			
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist		DEC 0 2 2010 / Lever B. D.	ale			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Guch Month Day 24 Year Milos 2:00 A M November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F Director 212-90-1361 16, 1963 Marvland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 Tes 2 X No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1951 Dineen Drive 21222 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. , or Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Construction 11 <u>Laborer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Milos Guch, Sr. Wilma Lee Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Tina Haddix / Sister 1932 Haselmere Road, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) ArdentCremation, Inc. 11-30-10 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final AIDS End-Stage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 2 should be detached for Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\stackrel{\checkmark}{\square}$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?

Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 2 📑 No 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MSKEY WORLNIM.D D0057465 11124/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 212 D9. 5mith AV-5-203-N-5, Rajapakse, M.D 2835

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37693 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 December 9:20 A M Eliese Keigler Gore Anna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec 13, 1927 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🛛 F Months Days Hours Mary Land 214-26-1967 Dec Director 82 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a State Director 1 Yes 2 X No Maryland Timonium Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 2525 Pot Spring Road, apt. S520 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eliese Doering Arthur Keigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Gore/Son 302 Atlantic Avenue, West Cape May, 08204 NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/8/10 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Valley Memorial Gardens Timonium, Maryland Dulaney 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road. Timonium. Maryland 21093 21. Signature of Funeral Service Lignates Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-transi Due to (or as a consequence of): Physician/Medical iding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 TO Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funeral X Natural
Accident 5 Pending Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 30. Name and and dre

31. Date filed (Month, Day, Year)

JONES,

a.m.

SORE

ANNA

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 28 2010 Physician/ 8:56 THOMAS ANTHONY GENNARO, JR. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 6. Sex 1 🕅 M 2 🗆 F 7. Age (In yrs. last birthday) **Funeral** December 5, 1969 Pennsylvania Days Min Months 40 Director 140-74-3570 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🔯 No North Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20852 United States 5440 Marinelli Road #121 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education during most of working (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmatts. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Defense Software Engineer 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Ann Henry Thomas Anthony Gennaro, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5440 Marinelli Road #121, North Bethesda, MD 20852 Diana Gennaro/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 20c. Location - City or Town, State 20a, Method of Disposition December 2 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home, Chevy Chase Signature of Funeral Sergice Ligenspe Houon 20814 M01530 Mou 17557 Wisconsin Avenue, Bethesda, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician/ CO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Secus tally 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? death? 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 60 D

∖© State

Registrar

DHMH 17 Rev 7/2009

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avole

31. Date filed (Month, Day, Year) **DEC 0 2 2010** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State C6	ertificate of Death	Reg. No.	
Physician/	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 1710 hrs	
ledical Examiner	<u> </u>	4b. City, Town, or Location of Death	November 23, 2010	
	4a. Facility Name (if not institution, give street and number)  48 S. Dundalk Avenue #C	Dundalk	Baltimore County	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 213 – 80 – 9072	Months Days Hours Min	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MTD	
Bircotor	213-80-90/2 1 M 2 F 43	Yrs.	10 21 1307	
any	10a. State 10b. County 10c. Cit	y, Town or Location	10d. Inside City Lim	
<b>≹</b> ,,	MD Baltimore Du	ındalk	1 X Yes 2I	No
the Maryland of or 28a-f show iffed at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
th the Maryland 23a or 28a-f sho notified at once.		21222	USA secify Yes or No- 14. Race - American Indian, Black,	
death with r items 23 nust be no uneral	11. Marital Status 1 Never Married 2 Married Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (See If Yes, specify Cuban, Mexican, Puerto		
er dea	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: White	
ours aft	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done 16b. Kind of Business/Industry	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland realth and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+)	Waitress	Food Service	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica TO Be Comple	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
215- be filed ntal Hy rked of ent, the		Shelia	Rehm	
213 ould b d Men s marl ic eve			Rehm Rural Route Number, City or Town, State, Zip Code)	
Tore, MD 2 ages 1 and 2 shou nt of Health and N tt: If item 27 is n other traumatic	Dawn Schmidt - Sister	3105 Chesterfield  D. Place of Disposition (Name of cemetery,	Rd., Raltimore MD 212  Date 20c. Location - City or Town, State	<u>:13</u>
ore, es l an of Hee If ite	1 Punicl 2 Cremation 3 Removal from State	crematory or other place)		
E 9 8 8 9	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee		-30-10 Glen Burnie, MD	
Balti permit. Departu Import		DA 2134 Willow	adley-Ashton Funeral Ho	me
Physician	23a. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line.	th. Do not enter the mode of dying, such as cardiac	2011100110111	
/Medical Examiner	Immediate Cause (Final disease a. Methadone In		Death	
	or condition resulting in death)  Due to (or as a consequence	e of):		
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e of):		
ted to no no no no no no no no no no no no no	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence	e of):		
760, icate be executed physician and the burial - transit	d.  MI UNPENDED AMENDED 23a, 27	,28a-f per me g910 12-2	7-10 vt	
760, cate be execu physician and he burial - tra	IF FEMALE: 23c. If yes, outcome of pr		23d. Date of delivery	
3876 rtificat ing ph as the		2 Fetal death 3 Ectopic pregr	ancy Month Day Year	
. Box 68760, the death certificate by the attending physic ched for use as the but Physician/Mec	past 12 months:  4 ☐ Pregnant at time of  1 ☐ Yes 2 ☐ No 9 ✔ Unknown  g ☐ Unknown	death 5 Other (Specify)		
D. Be trucked to by the ached to		ot resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	
res that the signed by I be detach			1 Yes 2 No 3 Probably 4 Unknov	
ords, w requir ls been s should I			24a. Was an autopsy 24b. Were autopsy findings availar prior to completion of cause	
Records, The law requires freate has been signage 2 should be Completed			performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No	)
Vital Recysician: The his certificate director, page	25. Was case referred to medical	26.Place of Death (Check		
f Vit	examiner?  1  Yes 2 No  17 Hospital: 1 Inpatient 2  27. Manner of Death  28a. Date of Injury	ER/Outpatient 3 DOA Nurs  28b. Time of Injury 28c. Injury at Work?	ing Home 5 Residence 6 ✔ Other: Scene	
nding Ph th :: After t e funeral	1 Natural 5 Pending Fd 11-23-10	fd 5:00 pm 1 Yes 2 X No	unknown	
Division of Vital Records, spital or Attending Physician: The law requirt ours after death neral Director: After this certificate has been si filled in by the funeral director, page 2 should be certification. To Re Completed	2 Accident Investigation 3 Suicide 6 X Could not be	t home, farm, street, factory, office building, etc.	28f. Location (Street and Number of Rural Route Number of Town, State) 48 S. Dunda Lk Ave	City
Div spital o tours af neral D filled i	4 Homicide determined (Specify) ho	use	#C Dundalk, Md.	
		ledge, death occurred at the time, date and place, ar n and/or investigation, in my opinion, death occurred	id due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)	
To the Ho within 24 To the Fu completely	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
	Laurek Frenchast MAR	O.C.M.E.	November 24, 2010	
	30. Name and address of person who completed cause of death (I		MD 24204	
	Pamela E. Southall, MD Assistant Medical E		IVID 2 IZU I	
Stat Registra		B. Sevel		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ HARRIS 11:00 A M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Himore Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 M 2 D F Min. (Month Day, Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 1 Yes 2 □ No timore 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Iac 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or, Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ral Services to MD21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARDIOVASCI Immediate Cause (Final RIOSC Physician/ disease or condition Medical resulting in death) ∫ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown the been signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed PROSTATE CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical

within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month) Day, Year) 29b. Signature and title 29c. License number 2010

2122

30 Name and address of person who completed cause of death (frem 23a) (Type, Print) 324 2

31. Date filed (Month, Day, Year) State 2010 2 Registrar

29a Certifier

32. Registrar's Signature

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  AMEND ITEM#7 perfft, G910, 12/3/2010, WS State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene  1 - For State Amend Item 1 per dr., g910, 12/01/2010dnb Certificate of Death Reg. No. 37697									
		-	- State Amend Item   Registrar	per dr.,g910	0,12/01 Cert			Re	g. No.	3/69/
	Physicia Medic		1. Decedent's Name (First, Middle Last)	HSt	Jear	D. H	itchens	2. Date of Death	1 € <sup>ay</sup> 2010	3. Time of Death
	Examin		4a. Facility Name (if not institution, give st. 1622 Michelle	reet and number)		Fores	r Location of Death		4c. County of Deat	d
	Funeral Director		219-38-9200	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, ) 3 - 14 -		thplace (State or Foreign untry)
	/land f show ed at	tor	Usual Residence of Decedent  10a. State 10b. County		, Town or Loca	ation				10d. Inside City Limits
	or 28a-	Director	MD na	150	110	10f. Zip Code		10	ng. Citizen of What Co	
	s 23a c	Funeral	1352 Winston	Avenue			239		USA	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1  1 □ Never Married 2 □ Married  3 ♥ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.		as Decedent of Hes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Black Specify:	e, etc.
15-0	72 hour r "natu edical	plet	15. Decedent's Edu (Specify only highest grad		(Give ki	ent's Usual Occu ind of work done NOT use retired	during most of wor	king	16b. Kind of Business	Industry UN
21215-0036	within giene. er thar the M		Elementary/Seconday (0-12)	College (1-4 or 5+)		Salespe	,			
	ld be filed within Mental Hygiene. iarked other tha atic event, the I	To Be	17. Father's Name (First, Middle, Last)  TOMN Butley			,	18. Mother's Nan	ne (First, Middle, Ma Brake	aiden Surname)	
Maryland	hould band Me is mark numation		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing	g Address (Street	and Number or Ru	ral Route Number, (	City or Town, State, Zi	p Code)
	and 2 s Health s tem 27 i		Kim D. Quickley	-12-0-0-1	135°	Un5)	ton Avenue		Co. Location - City or	Town State
mor	Page 1 nent of ant: If it ıry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, crem	atory or other pla Memorial	: ,		Arbutus,	
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licenses		22.	Name and Addre	ess of Facility M	arch Eas		MD 21202
	40200		23a. Part 1. Enter the disease, or compl	cations that caused the death						Approximate Interval Between/ /
	Hysician/	19	shock, or heart failure. List only one Immediate Cause (Final disease or condition	Cause of each line.	table	200a	Sur?	an 005	_	Ons t and Death
أميدا	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
	d St. d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
p.	executed an and ial-transi	Exal	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
	ate be physicia the bur	edica		I						
Box 68760	Attending Physicians. The law requires that the death certificate be executed sr death.  sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Very 10 ☐ Unknown	3c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗔	Ectopic pregnar Other (specify)	ncy /	11	23d. Date of de Month	elivery Day Year
P.O.	iires that the dea n signed by the a Id be detached f	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause g	jiven in Part I.			o the cause of death?
rds,	requires been sig hould b	eted				<u></u>		1 LJ Ye		Probably 4 Unknown utopsy findings available
3eco	he law te has l age 2 s	dwo						autops perform 1 \(\supers \text{Yes} \) 2	y prior to	completion of cause of
ital	ician: T sertifica ector, p	Be	25. Was case referred to medical examiner?	ospital:		_ lot	Place of Death (Che	ck only one)	. /	Daughteris
of V	g Phys er this neral dir	te: To	27. Manner of Dea	1  Inpatient 2  28a. Date of injury (Month, Day, Year)	28b. Time of injury	t 3 DOA 28c. Inju	4 ∐ Nursing F ury at	dome 5 Resider 28d. Describe how	nce 6 \ Other (Spe w injury occurred	city) + will House
ion	ttendin death. tor: Aft the fur	Certificate:	1 Valural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho		M 1	Yes 2 No	20f Location (Str	reet and Number or Re	ural Route Number
Division of Vital Records,	To the Hospital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should	Cer	4 Homicide determined	building, etc. (Specify		et, lactory, office		City or Town,		and House Marrious,
	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	Medical	(Check P Medical Examin	cian: To the best of my knowler: On the basis of examination  Practioner: To the best of my	and/or investi	igation, in my opir	nion, death occurred	at the time, date and	d place, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	Traduction to the post of my	, momeage, a		se number		9d. Date signed (Mon	
	00		30. Name and address of person who co	meeted cause of death (Item	23a) (Tyne P	rint)	00577	44 1	4/17/6	U
_	20		Shery weinst	Ech Maye	rlot	topk	ns fla-	Za,Ba	Homor	EM 2(20)
	Sta Registr		31. Date filed (Month, Day, Year)	72. Registrar's Signa	and far	Ked		,		

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AMEND ITEM#19a, b, per INF, G910, 12/7/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BETTY R. HAYWOOD NOVEMBER 2010 6:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LIBERTY HEIGHTS NURSING & REHAB.CNT BALTIMORE 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🗶 F 94 Months Days Hours Min. (Month, Day, Year) 10-29-1916 Country) 237-18-2592 NC Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director must be notified 1X Yes 2 ☐ No 28a-f BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Funeral 23a USA 3814 BONNER ROAD 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 Yes 2 No ģ 1 Never Married 2 Married ò Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" Completed 3 XWidowed 4 ☐ Divorced BLACK the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) LPN HEALTH other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H

27 is marked of

traumatic ever 2 BENJAMIN F. ROGERS FLONNIE THOMPSON Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print)
Harold Cruse/Son
BARBARA GOBB/DAUCHTER 195381174 Andress (Street and Number of Burle Number, City of Toy of State, Zip Code) APT. 58 Health a 1311 DELAWARE AVE. S.W. WASHINGTON, DC other 1 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ð Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CROWNSVILLE VET.CEM. 12-7-2010 CROWNSVILLE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Signature of Funeral Service Licensee a 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/  $\forall$ disease or condition Medical resulting in death) r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birtn
Pregnant a
Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 1 Yes 2 been signed by the a should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an s certificate has b director, page 2 sl autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred injurv 5 Pending work?
1 Yes 2 No s after decaral Director; A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in 24 hou. Ne **Funeral Dir**o A filled in bv determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 23a) (Type, Print) 30. Name and address of person who completed cause of

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			1 - State of Maryland / Department			eg. No.	37699				
	Physicia Media		1. Decedent's Name (First, Middle, Last)  Mary Elizabeth Haifley		2. Date of Death	Day 2010 Year	3. Time of Death 9:39 A M				
	Examir			own, or Location of Death		4c. County of Dea					
	Funeral Director	Г	5. Social Security Number 6. Sex 1 $\square$ M 2 $\square$ F 7. Age (In yrs. last birthday) If Under Months $\square$ Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, 5 – 26 – 1	year) 9. Bir 931 MD	thplace (State or Foreign ountry)				
	land show d at	ţoţ	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location				10d. Inside City Limits				
	the Mary or 28a-f e notifie	Director	MD Carroll We	estminster	I 1	0g. Citizen of What Co	1 🔁 Yes 2 □ No				
	ath with ome 23a must b	Funeral	149 E. Main St.  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decede	21157		USA					
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☒ Married 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes ☒ ☐ No 1 ☐ Yes 2 ☒ ☐ No 1 ☐ Yes 2 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ Yes 2 ☐ 1 ☐ Yes 3 ☐ 1 ☐ Yes 3	nt of Hispanic Origin? (Spy Cuban, Mexican, Puerto	Pican, etc.)	14. Race - Ame Black, Whit Specify: <b>Wh</b>	e, etc.				
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	filed with al Hygien I other the vent, the	Be	11 Secret  17. Father's Name (First, Middle, Last)		ne (First, Middle, M	Real Esta Haiden Surname)	ate				
Maryland	ould be and Menta	은	David J. Baile  19a. Informant's Name/Relationship (Type, Print)  19h. Mailing Address (	Sarah . Street and Number or Rui	E. Study		- Codel				
	and 2 sh Health ar em 27 is ther trau		William F. Haifley-husband 149 E.  20a. Method of Disposition  20b. Place of Disposition (Name	Main St.,	Westmin	ster,MD 2	21157				
Baltimore,	Page 1 ment of l tant: If it		1 ☐ Baust Church  1 ☐ Donation 5 ☐ Other (Specify)			20c. Location - City or Westminst					
Bal	permit Depar Impor any in			Address of Facility Flo							
	Ph_sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   WETASTATIC LOBULIC CHECKUM OF BROOK TO STATIC CONTROLLS AND CONTR								
	Examiner	بد	Due to (or as a consequence of):  Sequentially list conditions,  b.								
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no.	icate be executed g physician and is the burial-transit	Medical Examiner	resulting in death) Last  Due to (or as a consequence of):								
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Division of Vital Records,	Hospital or Attending Physician. The law requires that the death certif 24 hours after death. 24 hours after death. 4 Funeral Director. After this certificate has been signed by the attending eted filled in by the funeral director, page 2 should be detached for use a	Completed by			24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of				
Vital	ysician; s certific director,	To Be	25. Was case referred to medical examiner?  1	26. Place of Death (Chec	k only one)	nce 6 🖺 Other (Spec	Dovertion				
n of \	ding Phy th. After thi funeral o		27. Manner of Death  1 Natural 5 Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury injury	injury at work?  1 ☐ Yes 2 ☐ No	28d. Describe how		ny)				
Divisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined See. Place of Injury - At home, farm, street, factory, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,				
_	e Hospit 24 hour e Funera	Medical	29a. Certifier (Check (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in my only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in my only one)	opinion, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.				
	To the within 2 To the comple	<		icense number		d. Date signed (Month	, Day, Year)				
	4		30. Name and address of person who completed cause of death (Item 23a) (Type Print)	Sver Aven	او دياو						
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / Depart		lental Hygien	e 2010	07700
			State Registrar	Certif	icate of Death	Reg. I	10.4UIU	3//00
	Physicia Medic		1. Decedent's Name (First, Middle, Last) And CeW M	Jefferson		2. Date of Death  Month  DVEMDE	29.2°10	3. Time of Death A 0158 M
	Examin		4a. Facility Name (if not institution, give st		o. City, Town, or Location of Death		c. County of Death	
, marke	Funeral		5. Social Security Number 6. Sex		Funder 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		228-38-6639   1 X	M 2 □ F 76 Yrs. M	onths Days Hours Min.	OCT. 19, Year	34 Vir	ginia
land	fshow	tor	10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits
e Man	or 28a- notifie	Director	10e. Street and Number	Balty	MOCE 10f. Zip Code	100	Citizen of What Cou	1 XYes 2 No
with th	s 23a c	Funeral	1929 Mosh	er St.	21217	Tog. v	USA	iliy:
r death	or item niner n		11. Marital Status 1 ☐ Never Married 2 Married 1	Armed Forces?	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036 within 72 hours after death with the Marvland	f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ted by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	Yes 2 No Specify:		Specify: B	ack
215-0	an "nat Medic	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Give kind	's Usual Occupation I of work done during most of worki OT use retired	ing 16b.	Kind of Business In	dustry
212 Within	ygiene her tha it, the	Be Co	Elementary/Seconday (0-12)	College (1-4 or 5+)	he Operate	or Le	ckeI	nsulation
Maryland 2 should be filed	Mental Hygiene la <b>rked other th</b> a atic event, the I	To B	17. Father's Name (First, Middle, Last)	efforson Sr	18. Mother's Name	e (First, Middle, Maide	n Surname) Ruf	fin
<b>fary</b> should	and M is mai aumat		19a. Informant's Name/Relationship (Type	Print) (wife) 19b. Mailing A	ddress (Street and Number or Rura	l Route Number, City	or Town, State, Zip (	Code)
	Health tem 27 other tr		NICS, Doris, 20a. Method of Disposition	Jetterson 1929 20b. Place of Disposition	NOSher S	Date 20c.	Location - City or To	d. 21217
altimore,	0		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State King Men		+/2010 E	Balto.	Md.
Balt	Department Important: I any injury o		21. Signature of Funeral Service Licensee	Jay Jos	ame and Address of Facility	uneral t	ome, P.A	21211
			shock, or heart failure. List only one	ations that caused the death. Do not enter th cause on each line.	e mode of dying, such as cardiac c	or respiratory arrest,		Approximate Interval Between
	ysician. Medical		Immediate Cause (Final disease or condition resulting in death)	Due t' (or as a consequence of):	- INHARCTI	01		Onset and Death
E	xaminer	L I	Sequentially list conditions, b	Atheraschone	Coronary Ar	pry DZ		
ted	d tnsit	Examiner	arrany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of).  HYD 1-	Hersim			
Box 68760 death certificate be executed	physician and the burial-transit	al Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	,			
<b>760</b> cate be	physic s the bu	edical	d					
x 687	tending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy	ctopic pregnancy	ļ.	23d. Date of delive	
. Box he death o	y the at ched fo	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time of death 5 ☐ 0 9 ☐ Unknown	ther (specify)		Month	Day Year
, P.O	gned b	b	Part II. Other significant conditions conf	ributing to death but not resulting in the under	rlying cause given in Part I.		use contribute to th	
rds	been si should	eted		Diahole)		1 ☐ Yes 24a. Was an		pably 4 Unknown
Vital Records, ysician: The law requires	ate has bage 2	Completed		3 000 1-00		autopsy performed?	prior to co death?	mpletion of cause of
ician:	ector, p	Be	25. Was case referred to medical examiner?	spital:	26. Place of Death (Check			
of V	er this e	:e: To	27. Man of Death	1 Inpatient 2 PR/Outpatient 3 28a. Date of injury 28b. Time of	28c. Injury at	me 5 Residence 28d. Describe how inju		)
ION tendin	leath. Ior: Aft the fun	Certificate:	tural 5 Pending Accident Investigation Suicide 6 Could not be		work? M 1 ☐ Yes 2 ☐ No			
DIVISION OF lal or Attending Ph	s after of Direct of in by			28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street a City or Town, Sta		Route Number,
e Hospit	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Medical	(Check 2 \( \sum \) Medical Examine	an: To the best of my knowledge, death occu r: On the basis of examination and/or investigat Practioner: To the best of my knowledge, deat	ion, in my opinion, death occurred at	the time, date and place	ce, and due to the ca	use(s) and manner stated.
To th	withir To th	-	29b. Signature and title of certifier		29c. License number		ate signed (Month,	
			30. Name and address of person who con	pleted cause of death (Item 23a) (Type, Print	1 104 757 7	1 1	441	0
			ANTHONY R. T	JOSOPH NO 1/94		1,212	23	
	Stat Registra		31. Date filed (Month, Day, Year)  DEC 0 2 2010	32. Registrar's Signature				
				- Ja. 1-				

DHMH 17 Rev 7/2009

Full Property   Format   Secretary   Format   Sec					pe or Print in Black					07701
Physicians   1. Diseased in Name (Pinct, Mode), Last   2. Described in Name (Pinct, Mode), Last   3. Described				For State				/lental Hygier	ne_UIU	3//01
Martin   M				Registrar	C	ertificate of Dea	ath		No.	
South South Profession of December   100 common   100 c		Medic	al	LERDY JAN				NOVEMBE		7
Display   Total   To	į		er	NORTHWEST HOS	SPKAL	RAMOA	215T1	MM	BA251	morre
The state of the s	ı			120-28-8970 151	4005	Months Days Ho		8. Date of Birth (Month, Day, Yea)	9. Birt	thplace (State or Foreign unitary).
23. Part 1. Enter the disease, or opticaltonic flat caused the composition of the control of the		aryland a-f show fied at	ctor	10a. State 10b. County	1	Location				10d. Inside City Limits
23. Part 1. Enter the disease, or opticaltonic flat caused the composition of the control of the		ith the Ma 23a or 28 at be noti	ral Dire	10e. Street and Number	l Qual	10f. Zip Code	100	10g.	Citizen of What Co	
23. Part 1. Enter the disease, or opticaltonic flat caused the composition of the control of the		eath w	-une		Was Decedent Ever in U.S. 1	3. Was Decedent of Hispan	nic Origin? (Spe	ecify Yes or No-	14. Race - Ame	rican Indian,
23. Part 1. Enter the disease, or opticaltonic flat caused the composition of the control of the	036	rs after de ral", or it Examine	by		1 ☐ Yes 2 ☑ No If Yes, Give			Rican, etc.)	Black, White	
23a. Part 1. Enter the disease, or eye-fillications that caused the disease or respiratory arrest, wheeld of the proposed of t	5-0	'2 hour "natu edical	plet		completed) (Gi	ive kind of work done during	n g most of work	ing 16b	. Kind of Business	Industry
23a. Part 1. Enter the disease, or eye-fillications that caused the disease or respiratory arrest, wheeld of the proposed of t	12121	d within 7 lygiene. ther than nt, the M		10	College (1-4 or 5+)	ruck Di			Priv	ate
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23. Part 1. Enter the disease, or opticaltonic flat caused the composition of the control of the	Mar	2 shou th and t7 is m traum		19a. Informant's Name/Relationship (Type,	Print) 19b. M	alling Address (Street and N	· programes			Code)
23. Part 1. Enter the disease, or opticaltonic flat caused the composition of the control of the		1 and of Heal item,								Town, State
23. Part 1. Enter the disease, or opticaltonic flat caused the composition of the control of the	Ei Ei	. Page Iment or tant: If jury or			novar norm State		101112	210 B	altimo	re, MD
23a. Part 1. Enter the disease, or carbibilations that caused the dishock, or heart failure. List of one cause on each line.  Physician Medical Examiner  Physician Medical Examiner  Examiner  Physician Medical Examiner  By Day 15 (1997)  Sequentially list conditions, if any, leading to immediate cause (final medical cause) (fina	Ball	permit Depart Impor any in once.		21. Signature of Fundral Stylice Licensee	010	22 Name and Address of	Facility Ru	ss Fune	ral Hon	er P.A.
Immediate Cause (Final disease or condition resulting in death)   Purpose of Cause (Final disease or condition resulting in death)   Purpose of Cause (Final disease or condition resulting in death)   Purpose of Cause (Final disease or condition resulting in death)   Purpose of Cause (Final disease or condition resulting in death)   Purpose of Cause (Final disease)   Purpose of Cause (Final diseas				23a. Part 1. Enter the disease, or complicat	tions that caused the d. Do not e	enter the mode of dying, su	ch as cardiac	or respiratory arrest,	160. W	Approximate
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underl	- P		8 0	Immediate Cause (Final disease or condition	SEP S				4	Onset and Death
Sequentially list conditions, large and property and prop				resulting in death)		<u> </u>				
The state of the s		*	iner	if any, leading to immediate		1				
The state of the s		ecuted and transit	xam	that initiated events	Due to (or as a consequence of):				- 4	
Spood of Specific Plane 1   23e. Did tobacco use contribute to the cause of death?    1   Yes   2   No   3   Probably   24b. Were autopsy findings an autopsy performed?   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   No   No   No   No   No		iris e			But to (or as a consequence oi).					
Spood of Specific Plane 1   23e. Did tobacco use contribute to the cause of death?    1   Yes   2   No   3   Probably   24b. Were autopsy findings an autopsy performed?   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   No   No   No   No   No	5876	ertificat ding ph	/Mec		If was outcome of pregnancy					-
Spood of the state of the cause of the cause of the state of the cause of the state of the cause of the cause of the state of the cause of the cause of the state of the cause of the cause of the cause of the state of the cause	Вох	e death or the atten ned for us	ysiciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal death 4 Pregnant at time of death					
1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   3   Probably   1   Yes   2   No   No   No   No   No   No   No	P.O.	that the led by detach	y Ph		outing to death but not resulting in th	e underlying cause given in	Part I.	23e. Did tobacco	o use contribute to	the cause of death?
24a. Was an autopsy findings a autopsy performed? 1   yes   2   No   No   No   No   No   No   No	ds,	quires quires and sign	ted b					1 🗆 Yes	2 □ No 3 □ Pr	obably 🙀 Unknown
The state of Death (Check only one)  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of injury  28. Linjury at work?  27. Manner of Death  28. Location (Street and Number or Rural Route Number of Building, etc. (Specify)  28. Place of Death (Check only one)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  28. Location (Street and Number or Rural Route Number of Signature)  29. Location (Street and Number or Rural Route Number of Signature)  29. Location (Street and Number or Rural Route Number of Signature)  29. Location (Street and Number or Rural Route Number of Signature)  29. Location (Street and Number or Rural Route Number or Rural Route Number of Signature)  29. Location (Street and Number or Rural Route Number of Signature)  29. Location (Street and Number or Rural Route N	cor	law rev has be le 2 sho	mple					autopsy	prior to c	opsy findings available completion of cause of
Residence   Specify   Sp	<u> </u>	in: The ifficate or, pag		25. Was case referred to medical		26 Place	of Death (Check	1 Yes 2	No 1 ☐ Yes	2 🗆 No
27. Manner of Death   1	∑ Kan	is cert direct		examiner?	oital: 1 ☐ Inpatient 2 ★ER/Outpa	Other:			6 ☐ Other (Speci	ify)
Part of the color of the colo	יס ל היים	Ing Pr			28a. Date of injury (Month, Day, Year) 28b. Time injury	e of 28c. Injury at work?				
Description of the cause(s) and manner as stated.  Solution of the cause(s) and manner as stated.	Sior	Attend r death ctor: /	rtific	2' Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,			28f. Location (Street a	and Number or Rur	ral Route Number.
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	<u>≥</u>	ortal or a	sal Ce	4 - Hornicide determined	building, etc. (Specify)			City or Town, Sta	ite)	
5556		e Hosp	Nedic	(Check 2 \( \subseteq \text{Medical Examiner:} \)	On the basis of examination and/or inv	vestigation, in my opinion, de	eath occurred at	the time, date and pla	ce, and due to the c	ause(s) and manner stated.
29d. Date signed (Month, Day, Year)	_ ;	To the within 2 То the сотрые		29b. Signature and title of certifier		29c. License num	nber	29d. [	Date signed (Month	, Day, Year)
D 00024970 NOVEMBER 28 2				1/1/10		OOVL	77/	N0	VEMBE.	1 28 2010
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CLIFF FABER MO 5401 620 COVAS ROAD RANDALLSTOWN MARYLAND 31. Date filed (Month, Day, Year)  32. Registrar's Signature				/ / /	540) 670 CDV	as road i	RAND	ALLSTON	v~ MA	MYZAND
State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  Registrar  DEC 0 2 2010			_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	,			<del></del>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per fn,g910,12/02/2010dnb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 11, 2010 Physician/ Dorothy Jackson 10:35 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Harford Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 91 Hours 04/22/1919 218-05-0042 VA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Funeral Director MD Harford Aberdeen 28a-f 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be 150 E. Deen Avenue 21001 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. þ ö 1 Never Married 2 Married Itimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced Completed Ith and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Edwin McIntosh Lizzie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Reveillie Poirier-Daughter 2852 Rossiter Ave., Roslyn, PA 19001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gardens 11/20/2010 Aberdeen, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Brent Francis per dvr 333 S. Parke St., Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ DYNCOPE JACKSON 11/11/2010 Medical Due to (or as a consequence of) FAILURE Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna Pregnant at time of death 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II**, Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SOROTHY or Attending Physician: The law performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 🔀 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. aad D0060532 Anunagia

Registrar
DHMH 17 Rev 7/2009

State

ANE ABERDEEN MD. 21001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:10 PM. Medical a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** Ka last birthday Social Security If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F YMonth, Day, Ye Months Hours Director Usual Residence of Decedent or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 ☐ No mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21229 USA Lational 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked other any injury or other. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) /Seconday (0-12) College (1-4 or 5+) pprator rachine Diamono Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည ohn lohnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Uphnson 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Catonsville Signature of Funeral Service License mo 21229 23a. Par Lenter the dissue, or complications that caused the death. Do not enter suck, or heart failure. List only one cause on , ach line.

Imm. diate Cause (Final Approximate Interval Between Onse and Death Physician/ disease or condition Medical resulting in death) consequence of Examiner Cequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Y Unknown ils certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed / Yes 2 No 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🕽 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After thi eted filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 27. Manuer of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Fune

completed file 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 31. Date filed (Month, Day, Yea

DEC 0 2 2010 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#22perFH, G910, 12/2/2010, WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Amey Johnson Month 8:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3611 N/AOakmont Ave **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 F Days Hours (Month, Day, Year) Director 62 /16/46 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/AMD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21215 3611 Oakmont Ave USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 XNo Maryland 21215-0036 Sp.A.frican Am 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Home Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Epsie Thompson unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 Morvia Rd, Balt., MD 21206 <u>Ernestine Brown/Guardian</u> Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/2/10 Balt.,MD vview Crematory F.S. PA 22. Name and Address of Facility 21. Signature of Funeral S Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cuncer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 🗹 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🗹 Natural injury 5 Pending ☐ Accident☐ Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c, License number Majapalmini O DU057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N-S-Rejapake, M.D- 2835 Sminh N-S-203, Baltimore, MO. 21209. · Kajapakse, M.D

State Registrar 31. Date filed (Month, Day, Year) **DEC 0 2 2010** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carolyn R. Jackson December 2010 12:58pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 409 Walnut Groove Road Essex 5. Social Security Number . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours 08/07/ 229-50-4240 74 Director ТX Usual Residence of Decedent or 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 Xo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 409 Walnut Groove Road USA 21221 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ρ Maryland 21215-0036 Hygiene. other than "natural", If Yes Give 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) : Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Lawrence Ima Knighten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Walnut Groove Rd., Essex. MD 21221 Samuel Jackson Spouse Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Final Journey Crem. 12/3/2010 4 Donation 5 Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility

Maryland Cremation
PO Box 1413, Baltin Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetai uc...
Pregnant at time of death 3 Ectopic pregnancy After this certificate has been signed by the atter funeral director, page 2 should be detached for a in the past 12 months? Month Year 5 Other (specify) Day 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 1 ☐ Yes 2 🗷 No 2 🗌 No 1 \sum Yes 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospita <u>م</u>| 1 Yes 2 1000 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 K Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred M Natural 5 Pending after death.

Director: Aff
d in by the fur 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

ark

9110 Philadelphia Road, Rosedale, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

32. Registrar's Signature

Sheila Alongi,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ cosm The Va AN CIVE Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1612 N. Calhoun St. Baltimore Social Security Number If Under 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 Year If Under 24 Hrs. 1 M 2 XF Months Davs Min 0470377936 74 215-34-9412 Maryland Director Usual Residence of Decedent or items 23a or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 1612 N. Calhoun St. 21217 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Is lo If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black "natural", 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry Federal Hill 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12)
12th Grade College (1-4 or 5+) Nursing Home Nurse Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond D. Coles Ruby S. Barrette and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Sean Coles(son) N. 1612 Calhoun St., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Nurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. PArk unk Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if a, y, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💯 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 🗌 Yes 2 🗌 No ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Decritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) 6939 Quif Name and address of person who

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 28,2010 Gertrude Kennedy November 7:30 AΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Dundalk Genesis Eldercare - Heritage Center . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🛛 F January 31, 1922 88 Maryland **Director** 217-16-8552 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Salt Lake South Jordan 1 🗆 Yes 2 🔀 No Utah 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 10284 Steeple View Court 84095 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail 12 years Sales Lady 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Susan Mullen Herbert Franklin Ridgell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10284 Steeple View Court, South Jordan, Utah Dennis J. Jones son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State December 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 1, 2010 4 Donation 5 Other (Specify) 21. Sig tun of Filmer Service Licenses <sup>22. Name and Address of Facility</sup> Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a Part 1. Enter the disease Part 1. Enter the disease, of c shock, or heart failure. List on emplications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine ysician and e burial-transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death Check only one) Be Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

Registrar

State

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e of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010  $A^{M}$ 2:30 November Sok Kyu Kim Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson 1218 Meadowlark Drive 9. Birthplace (State or Foreign Country)
S. Korea If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Funeral 1 X M 2 🗆 F Days (Month, Pay, Year) Hours Min. 70 Korea **Director** 2**13-**70**-**5330 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 🗆 Yes 2 😾 No Baltimore Towson MD 10f. Zip Code 10g. Citizen of What Country? 6 10e. Street and Number or items 23a Funeral **USA** 21286 1218 Meadowlark Drive death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Korean If Yes, Give 3 Widowed 4 Divorced "natura!" Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry e 1 and 2 should be filed within 72 I t of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Grocery/Liquor Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tae Soon Lee Sang Yong Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sh nt of Health a : If item 27 is 1218 Meadowlark Drive; Towson, MD 21286 Yoon Hak Kim 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ott 1 X Burial 2 Cremation 3 Removal from State Oulaney Valley Mem Gardens 12/2/2010 Timonium, MD 4 Donation 5 Other (Specify) 1050 York Road 22. Name and Address of Facility 21. Signature of Funeral Service Towson, MD 21204 Inc. Ruck Towson Funeral Home, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest h each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Carcinoma One year Physician/ ung disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequence in death). Due to (or as a consequence of) sician and burial-transit Exami Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months? Day ρ 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the a ld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 **X** No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28b. Time of 28a. Date of injury 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 24 hours after death. Funeral Director: After (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier November 30,2010

State Registrar

DHMH 17 Rev 7/2009

Towson, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Street
Manshall A Levene 6569 Nonth Charles

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Vear Month Physician/ imothy November PM -owder 2010 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltmore Oak Secous Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral #-3-1960 Davs Hours Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No MD timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene. 7 is marked other than "r day (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 2 permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark Rural Royte Number City of Town, State, Zip Code) 21228 Informant's Name/Relationship (Type, Print) atonsville, mD Dister 20c, Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 12/8/10 1 Burial 2 Cremation 3 Removal from State Trotadomaparki injury or 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funera Bervice Licensee any in Nat' U Balto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cute Physician/ Myocardial Interction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atheroschemic vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 X Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 X Natural iniury 5 Pending death. Accident Suicide Investigation within 24 hours after deat To the Funeral Director Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MIKdashimD 11/27/2010 00038046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cathedral street Bollmane, MO 21201 McKdashi (000) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 2 2010 arka Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month NOV. Day 30 Physician/ Elizabeth J. Labadie 2010 4:55 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death aminer Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) (Month, Day, Country) Michigan **Funeral** Days Min Yea 1 □ M 2**X** F 83 382-20-8394 Jan. **Director** Usual Residence of Decedent 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director MD Baltimore City N/A 1 XYes 2 No 10g. Citizen of What Country? 10f. Zip Code 9 10e Street and Number Examiner must be 23a United States Funeral 21201 13 West Mulberry Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. ō, à 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: White Specify: If Yes, Give "natural", Completed 3 Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 National Mining al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Association 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fisher is marked or permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or other ဥ Mary Louise Moquin Edward Borlase 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 West Mulberry St., Baltimore, Maryland 21201 Kevin Labadie Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/30/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final h sician/ astro intom disease or condition resulting in death) dical Examiner to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? certificate | 1 ☐ Yes 2 ☐ No spital or Attending Physician: Thours after death.

neral Director: After this certificat dilled in by the funeral director, pi 26. Place of Death (Check only one) Be 25. Was case referred to medica Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check `3 □ only one 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier er 302010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

U % ZU II

Margaret Kelly Lane Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 28, 2010 0911 hrs **Medical Examiner** Margaret Kelly Lane 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 4200 East Fairmount Avenue 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign **Funeral** Country) Months Davs Hours Director 212-27-9473 1 M 2 XF 23 March 24, 1987 Maryland Usual Residence of Decedent Iny 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo 28a-f show Maryland Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Punte Lane 21221 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 2 X No 1 Yes 2 No specify: Yes, Give Year Specify: White 4 Divorced Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patricia A. Fitzpatrick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21236 æ Robert E. Lane
19a. Informant's Name/Relationship (Type, Print) Meg Newberger/Aunt 7Lake Forest Court, Nottingham, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ArdentCremation,Ind.12-2-10 |Hanover, Maryland 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel, P. 6009HarfordRoad, Baltimore, Maryland21214 nechall maruel 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and //whiteal Death Methadone intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and sician/Medical AMENDED 3a, PII, 27, 28a-f, per ME g910 12/7/10 TT attending physician a or use as the burial -X UNPENDED Box 68760, IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Phy of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 歹 1 Yes 2 No 3 Probably 4 ✔ Unknown Cocaine and heroin use Completed this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? l ✔ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 1 Yes 2 No Director: death Fd 11/18/10 Fd 8:50 am 2 \_\_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4200~E . Fairmount Ave Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be (Specify) found on street determined 4 Homicide 29a. Certifier (Check only)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

**ORIGINAL** 

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) November 29, 2010

within 24 hours a To the Funeral I

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

and manner stated.

Medical

State Registrar

29b Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ancis PM :16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Taruland Medica Certer Caltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign NY Country) (Month, Day, Year) -14-1925 1 🔀 M 2 🗆 F 85 Months 105-18-2525 Director Usual Residence of Decedent 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Carroll Westminster MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 691 Windsor Dr. 21158 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Masonry Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en ပ Giuseppe Latini Lucia Sassano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2047 Don Ave., Westminster, MD 21157 Michael F. Latini-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 12-10-10 Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD . Signa pr Funeral Service Lice 22. Name and Address of Facility Fletcher Funeral Home bonus 254 Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ dicoulma disease or condition Medical resulting in death) Due to (or as a con sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy signed by the atter 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☒ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🖾 No 1 Tes Other: မ 1 Minpatient 2 ER/Outpatient 3 DOA Director; After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) te: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending Certifica Accident hours after death. Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 1030 29

4T\
State

DHMH 17 Rev 7/2009

Registrar

30. Name and address of

31. Date filed (Month, Day, Year)

21201

Hinry Mallimat

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month nomas u 26 2010 /Medical 4a. Facility Name (If pot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** Kingstor Baltimone If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 08 30 1 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 64 214.44.T2 Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Xes 2 No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 3817 Stokes Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Black ≥ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive quip ment Uperator 12th grade NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. McNeill Margaret ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taylor atrice Road andalistanin MD 21133 20c. Location - City or Town, State Pages 1 tment of H 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or c 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Woodlawn Cemetery 1204 10 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Valuann C. Greene Funeral sycs Road Randallstann MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause ( Approximate Interval Between Onset and Death **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a □Yes 2□No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed certificate Division of Vital 1 □Yes 2 No 1 ☐ Yes 2 No this certific al director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔼 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29071 11-30 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

ANANDA KRISHNAN

31. Date filed (Month, Day, Year)

DEC 0 2 2010

32. Registrar's Signature

821 N. EUTAN ST #305 BALTIMERE MAZIZO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ 101	partment of Health and Nertificate of Death	Mental Hygier	ZUIU	37714
İ	Physici		1. Decedent's Name (First, Middle, Last)  CARRED (S) (S)		2. Date of Death Month	Pay Year	3. Time of Death
Y	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	1 7701
	-Admin		Harford Garden	Baltimore		na	
	Funeral Director		5. Social Security Number  244-36-5090  6. Sex 1 □ M 2  F   7. Age (In yrs. last birthda  Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 6-14-19	r) Cou	place (State or Foreign ntry) N.C.
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryl -f sho fled a	tor	MD na Baltim	nore			1 XYes 2 No
	th the or 28a e noti	)irec	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	ntry?
	23a ust b	ral	1112 N. Lakewood Avenue	21213		USA	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show important: If there 27 is marked other than "attural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ X No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Bla	etc.
	2 hour	ed b		cedent's Usual Occupation n/	a 16b.	Kind of Business/Ir	ndustry n/a
61712	I within 72 piene. r than "na the Mediu	Completed	(Specify only highest grade completed) (Gillie Elementary/Secondary (0-12) College (1-4or 5+) life	cedent's Usual Occupation  ve kind of work done during most of work  b. DO NOT use retired)	ing		, ii, a
2	e filec al Hyg othe	BeC	17. Father's Name (First, Middle, Last) Unk		e (First, Middle, Maid	,	
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ָט ע	s 1 an f Heal item 2 other	- 8	20a Method of Disposition 20b. Place of Dis	position (Name of		Location - City or T	
	Page: ient o nt: If i		Burial 2 Uremation 3 Unemoval from State	rematory or other place) mel Cemetery 12	-4-10 B	alto, MI	)
2	permit. Departm Importa any Inju once.		21. Signature of Funoral Service Licensee	22. Name and Address of Facility	March Eas	st F/H	
0	9 9 E E O	9.7	Strette K. Jones	1101 E. North A		alto,MD	21202
		x :	23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.		or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	menta			
	Examiner		Due to (or as a consequence of):				
ď.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
,	ecuted Ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
200	cate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
000	ficate physics sthe	dica	d				
200	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the I completely filled in by the funeral director, page 2.	Physician/Medical	1 Ves 2 No 4 Pregnant at time of death	3⊡Ectopic pregnancy 5⊡ Other <i>(specify)</i>	(	23d. Date of deliv	very Day Year
)	at the by the	hys	9 ☐ Unknown				
colds, r	quires tha	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to 2 ☐ No 3 ☐ Pro	the cause of death?
ממנו	The law re te has bee age 2 sho	Completed			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ğ	lan:   rtifica tor, p	Be C	25. Was case referred to medical	26. Place of Deat	1□ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No 1 □ Yes	2 □ No
5	hysic his ce I direc	To E	examiner? 1   Yes   Hospital: 1   Inpatient 2   ER/Outpat	ient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 □Other (Spec	ify)
	ing P		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 28b. Time Injury 27cm 28b. Time 2bb. Time 2bb.	y Work?	28d. Describe how in	jury occurred	
2	death ctor: y the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined to be determined.	M   1 ☐ Yes 2 ☐ No   street, factory, office	28f. Location (Street	and Number or Rui	ral Route Number
2	al or A after I Direct	ertif	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St		ar riodic rumbor,
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de (Check only one)  1 Certifying Physician: To the basis of examination and/or and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause rred at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier 2	29c. License number		Date signed (Month	
			) Just age (11)	D0069314	11	130/10	
	2		30. Name and address of person who completed cause of death (Item 23a) (Typ Mitted Prayaget 8873 Wealth	am Words ra 1	Entrale	mp 213	234
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 2 2010  Across 32. Registry's Signature				

Registrar
DHMH 17 Rev 7/2009

State

AMON

31. Date filed (Month, Day, Year)

3altimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

6701

MD

CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per INF G911 1/18/2011 JH State of Maryland / Department of Health and Mental Hygiene () For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Linda Miller Ann 26. November 2010 8:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 5401 Bradley Blvd Montgomery Bethesda Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, 1 M 2 TX Washington, DC **Director** 220-42-0639 65 1945 Sept Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at any pione. Tlorida County Broward 10c. City. Town or Location 10d. Inside City Limits Director Fort Lauderdale 1 🗌 Yes 2 😾 No Montgomery Maryland-Bethesda 10e. Street and Number 10f. Zip Code 2108 SE 21st Street 10g. Citizen of What Country? Funeral 33316 5401 Bradley Blvd 20814 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify. Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Investor Private Investing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert Weaver, Jr. Harvey Cecilia Tereasa Kenly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Frazier/daughter Bethesda, Maryland 20814 9500 Page Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/1/2010 Woodbine, Maryland 21. Sign three of Funeral Service Lice Going Home Cremation Service P.O. Beverly L.Heckrotte, P.A. Clarksv anita M00957 Momas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Adenocarcinoma of the Colon Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Pregnant
Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy perform 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital 1 🗆 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? injury 5 Pending 1 X Natural Natural
Accident
Suic work?
1 Yes 2 No after death Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 only one DOFACP 29b. Signatu d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) H45839 November 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Raffel 541 W. Cedar Lane Suite 203C Bethesda, Maryland 20814 32. Registrar's State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death Physician/ 1000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown **Baltimore** Seasons Hospice at NW Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Min. 72 9 M2nth/1938 216-36-3475 Baltimore, MD **Director** Usual Residence of Decedent show 10a, State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 No Brooklyn Park Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a U.S.A. 410 Cedar Hill Road 21225 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic except. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Carmen Joseph Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, MD 21228 Ms. Diane Bailey / Daughter 108 Wyndcrest Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12 1X Burial 2 Cremation 3 Removal from State Brooklyn Park, MD Cedar Hill Cemetery 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, ox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death signed by the a Id be detached for Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 KNo 1 🗆 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Tes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

31. Date file

2

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Richard McIntyre NOUMBIN 3:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arande Baltimerellashing Glen Bunnie Anne If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 01/23/1930 1 ★M 2 □ F Country) Illinois 336-22-6085 80 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Anne Arundel Co Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 United States 514 1st Avenue, SW 12. Was Decedent Ever in U.S. Armed Forces?

\*\*EXX Yes 2 \sum No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ filed within 72 hours after 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify. 3 ▼ Widowed 4 □ Divorced Completed White Year or Dates er than "natura, the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Cryptologist Agency Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. 2 Patrick Mary Herrin McIntyre Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 Glen View Court Arnold, MD <u>Mrs. lynne M. Zebrowski/Daughter</u> Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 12/4/2010 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Services PA: 2nd Ave SW: Glen Burnie. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 🗌 No been signed by the send should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform ☐ Yes 2 No 1 Yes 2 No this certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pendina of Funeral Director: After death.

e Funeral Director: After of the function o 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Franciscom To the local and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie Ovember 30,2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) More WASHIN 6000 32. Registrar's S State Registrar

DHMH 17 Rev 7/2009

SCHN4CR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Physician/ 27, 2010 McFadden November 10:55 PM Freda Lines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 604 Harrington Road Rockville 8. Date of Birth (Month, Day, Yea October 23 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours England 227-34-3449 90 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fire 27 is marked other than "natura!" ---" any injury or other trainers. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Rockville 1 Yes 2 No Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20852 United States 604 Harrington Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Force ģ 1 Never Married 2 X Married ☐ Yes 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Royal Air Force Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mabel Voce Frederick John Lines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmore D. McFadden / Husband 604 Harrington Road Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 20a. Method of Disposition 20c. Location - City or Town, State December 2 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 21. Signature of Juneral Service Lic 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home—Rockville, Inc.
300 W. Montgomery Avenue Rockville, Maryland 20850 MO1607 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Coronary Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Inferior Wall Myocardial Infarction Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of, attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Hypertensive Heart Disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 1 Yes Hypercholesterolemia page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\overline{\mathbf{X}}$  Residence 6  $\square$  Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 🖾 Natural 5 Pending 24 hours after death. Funeral Director: Af Investigation ☐ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047330 11/29/2010 Moin us 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Joseph, Rockville, Maryland 20852 50 West Edmonston Drive

Registrar

DHMH 17 Rev 7/2009

State

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November Flora T.ee Muth 27, 2010 7:08 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days August 29 1 □ M 2 🕱 F Hours Washington, D.C. Director 578-20-9948 88 Usual Residence of Decedent 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director District 1 X Yes 2 No of Columbia Washington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5111 Connecticut Avenue N.W. 20008 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ð 1 X Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event the Macainan Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Business Owner Artist Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Muth Edna Cassidy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Martinelli/ Niece 5909 Halpine Road Rockville, Maryland 20851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2010 Crematorium Bethesda, Maryland eral Service I 21. Signature of Fu Name and Address of Facility
bert A. Pumphrey Funeral Home-Rockville, Inc.
0 W. Montgomery Avenue Rockville, Maryland 20850 Robert 300 W. MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac, r respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on Cause (Disease or linjury attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ∐ Yes ⊆ g ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy perform certificate 2 No 1 Yes I or Attending Physician: after death.

Director: After this certifications 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 3 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Year 5:45A Dec. Syrmo Mandyli Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundal 112 Water Fountain Way, Unit103 Glen Burnie Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Greece 1 🗆 M 2 🔀 F (Month, Day Year) **Director** 86 220-41-0100 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified MD Anne Arundal Glen Burnie 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 23a or "natural", or items 23a or Funeral 72 hours after death with 112 Water Fountain Way, Unit 21060 Greece Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces 1 ☐ Yes 2X No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Own Home <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dimitrios Pyrpiris Panagiota Fari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 988 St. Johns Dr., Annapolis, MD 21409 Fay Escabar - Granddaughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ò 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Agios Andreas Cem 12-10-10 | Koskina Village of Funeral Service Licenses 21. Signature Bradley-Ashton Funeral Home Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) mento UPar Medical Due to (or as a consequence of) Examiner Meumonia Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant a 9 Unknown 5 Other (specify) Pregnant at time of death detached ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Hospital: 5 Residence 8 Other (Specify) 1 Yes 2 X No မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After iniurv 1 X Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 12/1/2010 11835 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7900 Mak rasadera. MD 21122 Point 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Evelyn Elizabeth November Napoli 27 20°10 3:32 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Towson 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 □ M 2**X**□ F March, 6 y, Yel 927 83 217-20-1966 mary and Director Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits must be notified at Director |Maryland Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21234 U.S.A. 3218 Woodside Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc , or þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: 'natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Thompson Gertrude Gallagher permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 370 Prospect Road Delta, Pennsylvania Leo Dobbs/ Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Gardens of Faith 1 X Burial 2 Cremation 3 Removal from State 12/1/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complication in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Onset and Death Physician/ PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Month Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>و</u> or Attending Physician; The law requires 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Number Praction is: To the past of my knowledge, and continued at the time, date and place, and due to the cause(s) and manner stated.

EVELYN NAPOLI

D.H.

3:32

2010

27,

NOVEMBER

A DHMH 17 Rev 7/2009

State Registrar

within 2 To the F

29b. Signature and title of

JACKIE JONES.

31. Date filed (Month, Day, Year)

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2300 DULANEY VALLEY RD.

32. Registrar's Signature

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death O wens Physician/ Cunthia Lee Month > Day 350 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Days Min <sup>Year</sup> 19<u>61</u> 49 Marvland Director 216-74-0522 Usual Residence of Decedent 28a-f shov 10b. County ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🎾 No Ellicott City Howard Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 3618 Mount Ida Drive **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cook Convent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ James Owens Phyllis Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3618 Mount Ida Drive Ellicott City, MD 21043 Takeia Owens, Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or otl once. cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/30/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 Shomas 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ulmonard disease or condition Medical resulting in death) **Examiner** venous Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 66515 2000 28 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.0.

Division of Vital

Cawat

32. Registrar's Signature

10710 Charter Drive Suite 310 Columbia, MD 21044

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10-09156 Richard Dougla	s Oı		pe or Print in B						.egibl	e. 2010	3772
		1- For State Registrar		Cer	tificate of	Death			Reg. No	).	
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		VA Hospital	on, give street and number	,		Baltimore		Death		o. County of Boar	
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Director		216-66-3690	1XM 2 F	5	54 Yrs.	Months Da	ays Hours	Min.	rz 2/	, 1956 Forei	<sup>gn</sup> <sup>ountry)</sup> Marylar
		Usual Residence of Decedent			, 1			j juailua	Ly 24	, 1930	
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121 d be fi ental arked vent,	Be	Douglas Granth		lge	T			ako Tanal			
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Balt permit. Depart Import injury		21. Signature of Funeral Service	Elicenses	00	(C)	nnelly	Funera	l Home of int Road,	Dur	ndalk, P. A	A. 21222
Physician		23a: Part I. Enter the disease, o		the death.	Do not enter the	e mode of dyin	g, such as car	diac or respiratory	arrest, sh	ock, or heart	Approximate Interva
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Box 68760 e death certificate b the attending physi ed for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outco	me of pregn	iancy			regnancy	23	d. Date of deliver  Month	y Day Year
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BO)	nysi	1 Yes 2 No 9 Ur	known 9 Unknown		٠ ت	o. 1 - 1 - 2 - 3 /					
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		6/11	1 SAA	X/r	(1)		.M.E.			ember 30, 20	
		30. Name and address of person	who completed cause of c	death (Item 2	23a)				Д		

State Registrar

ORIGINAL

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

UCIME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise Mildred Peach Month 1:30p м 29 Medical Nov. 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Nursing Center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 185-36-1910 1 M 2 X Months Days Hours Country) 97 March 9, 1913 **Director** TNUsual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 100 Roundup Road 21220 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: and Mental Hygiene. 3 X Widowed 4 Divorced Specify. Completed White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12th own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Joshua Ridgeway Queenie Cate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Koehler /niece 326 George Avenue Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State IndianTownGapNational 12/3/10 4 ☐ Donation 5 ☐ Other (Specify) Annville PA 21. Sign our of uneral Sirvice Lice 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ OTIC CARDIOVASCULAR Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CARCINOMA attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Dav Yes 2 No ed by the a detached i 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Nonknown 24a. Was an 24b. Were autopsy findings available nas autopsy performed Yes 2 prior to completion of cause of death? Director: After this certificate 1 Yes To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 **\**No မ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signatu

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

ilcel Place Dundalk

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08984 State of Maryland / Department of Health and Mental Hygiene Margaret Powe 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 23, 2010 0940 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death b. City, Town, or Location of Death 2018 West North Avenue Apt. # 15 **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Date of Birth (MM/DD/YYYY) Country) Months Days Hours Director 58-7273 1 M 2**X**F Yrs Jan.39 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 hours after death with the Maryland 10e. Street and Number 10g. Citizen of What Country ā 018 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married White etc. \_\_ Yes Widowed Divorced If Yes, Give Year 1 Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. MD 21215-0036 line 17. Father's Name (First, Middle, Last) item 27 is marked Be al Route Number, City or Town, State, Zip Code) 2120 19b. Mailing Address (Street and Number or 20b. Place of Disposition (Name of cemeter) 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 2 Cremation 3 Removal from State Donation 5 Other Spe 22. Name and 270 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Physician Between Onset and /Medical a. Intracranial Hemorrhage Death xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other: 4 Nursing Home 5 Residence 6 🗸 Other: Scene FR/Outpatient 3 DOA this 1 🗸 Yes Certification: To No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No 2 Accident

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: death. 24

Fo the Funeral Director: completely filled in by the

4 Homicide	(ope on ))		
29a, Certifier (Check only 1 Certifying Physician:	To the best of my knowledge, death occurred a	at the time, date and place, and due to the caus	e(s) and manner as stated.
	the basis of examination and/or investigation, dmanner stated.	in my opinion, death occurred at the time, date	and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Y
Caral H	allan	O.C.M.E.	November 24, 2010
20 Name and address of names who some	plotted paying of double (Horn 22a)		

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Investigation

Could not be

determined

3 Suicide

**Medical** 

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

28e. Place of Injury - At home, farm, street, factory, office building, etc

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year) November 24, 2010

or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 November 9:25 PM Marcella Marie Pac Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Parkville Oak Crest Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours January 6,1924 Baltimore, MD 218-18-8523 **Director** 86 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Phoenix Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o e ilcal Examiner must be Funeral U.S.A. 21131 12858 Stone Eagle Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 **X** No Completed by 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Me Ical any injury or other traumatic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Co. Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) မ Marie Jacobs Archibald C. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12858 Stone Eagle Road, Phoenix MD 21131 19a. Informant's Name/Relationship (Type, Print) Peter J. Pac/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 12/04/2010 Timonium, MD 4 Donation 5 Other (Specify) Dulaney Valley Memorial . Signature of Funeral Service License 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ sheime disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 4 Pregnant : 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has b autopsy perfor 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nerse Practioner: To the best of my knowledge, death undermad at the time, data and place, and due to the names of memor as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

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obin Patterson		State of Maryland / Department of Health and N	Mental Hy	giene	201	0 37728		
		Registrar		Re 2. Date of Dear	eg. No.	2 Time of Doub		
Physicia P≏dical Exami		1. Decedent's Name (First, Middle, Last)  Robin Delroy Patterson Sr.	ľ	Month November	3. Time of Death  0418 hrs			
		4b. City, Town, or Local Applications of the Company of the Compan	cation of Death		4c. County of D	Death		
		Sinai Hospital Baltimore			N/A			
Funeral				8. Date of Bir	th (MM/DD/YYYY)	Birthplace (State or Foreign Country)		
Director		220-64-4076 1 Months Days 51 Yrs. Months Days	Hours Min.	06/2	4/1959	Maryland		
,		Usual Residence of Decedent						
w any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No		
Maryland 28a-f show	to	MD N/A Balti	more	14	0.00			
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 10f. Zip Code			0g. Citizen of What	Country?		
with the ms 23a o	a D	4416 Belvieu 21215  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan	nio Origina / Cno		U.S.A.	merican Indian, Black,		
ath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Me			White, e			
her de		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No sp	pecify:		Specify: H	Black		
ours a	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation			16b. Kind of Busin			
6 72 ho ra "na	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO	) NOT use retire	a)				
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21215-0036 nuld be filed within 7 Mental Hygiene, marked other than c event, the Medica	ě.	Harry J. Patterson Sr.  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street an	Emma E			State. Zip Code)		
O € 5 ≈ £ 1	-	Spring Ferguson(sister) 523 N. FUlto						
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter		Date	20c. Location - Cit			
nor ages ant of at: If		1 K Burial 2 Cremation 3 Removal from State crematory or other place) 4 Departion 5 Other Specify: King Memorial Pa	rk 12/	01/10	Baltimo	ore.MD		
Baltimore, permit. Pages I al Department of He Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of F						
E P P III		gargueuxe Carne 2140°N. Fu	ılton A	ve.,B	altimore	MD 21217		
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such ailure. List only one cause on each line.	ch as cardiac or r	espiratory arre	est, shock, or heart	Approximate Interval Between Onset and		
Vedical. ≟xaminer	8 Y	Namediate Cause (Final disease a Sharp Force Injuries				Death		
		or condition resulting in death)  Due to (or as a consequence of):						
	直	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):						
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760, cate bo	Ş Ş	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivery		
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Box 68760, te death certificate be except the attending physician led for use as the burial -	Sic	1 Yes 2 No 9 Unknown 9 Unknown			1			
that the order by the detached	Ph.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23e. Did to	bacco use contribut	e to the cause of death?		
ords, P.C.	d b			1 Yes	2 🗸 No 3	Probably 4 Unknown		
ords, w requir	e e			24a Was autop		e autopsy findings available to completion of cause of		
tal Reco	Completed			perfor		h? Yes 2 No		
Vital Rec ysician: The l his certificate l	0		Death (Check or	nly one)				
Vit hysic	P P	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA				Other:		
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should the	Ë	27. Manner of Death  1 Natural 5 Pending Nov 25, 2010  28a. Date of Injury 28b. Time of Injury 28c. Injury at 1856 hrs 1 Yes	le le		now injury occurred bed and cut			
SiO	g	Accident Investigation   28e. Place of Injury - At home, farm, street, factory, office buildi		8f Location (9	Street and Number o	r Rural Route Number City		
Divisior pital or Attenc ours after death reral Director: filled in by the	1 Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide Accident 4 Homicide Accident 5 Pending Investigation 6 Could not be determined (Specify) Single Family Home Subject stabbed and cut							
Hospi 24 hou Funer ely fil	ပ	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and d	ue to the caus	e(s) and manner as	stated.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea						
F 3 F 3	Me	29b. Signature and title of certifier 29c. License nu	umber		29d. Date signed	(Month, Day, Year)		
		him him o.c.m.e	Ξ.		November 27	, 2010		
		30. Name and address of person who completed cause of death (Item 23a)	21201					
1	لِي	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	7 2 1 2 0 1					
St Regist	ate	31. Date filed (Month, Day Year) 32-Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD G910 12/6/10 TT

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Raymond Edward Reuling 2. Date of Death 3. Time of Death Month Year Physician/ :ZLPM Robert Edward Reuling OJEN 30 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMOVE SAINT SAINT AGNES
Social Security Number 6. HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Days Hours Min. Month Day, Ye 1924 Maryland 212-20-6775 86 Director Feb. Usual Residence of Decedent shov 10b. County items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 1206 Tugwell Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 🔀 Yes 2 🗌 No Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Internal Revenue Servic Accountant permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Louis Reuling Elizabeth Hackman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 206 Tugwell Drive; Catonsville, MD 21228</u> Elizabeth Reuling Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 12/6/2010 Baltimore, MD Donation 5 C Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Linens Part Y Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 00 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): use as the burial-transit signed by the attending physician and Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day 1 ☐ Yes 2 ☐ Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed this certificate Yes 2 WN Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred After (Month, Day, Year) Natural injury 5  $\square$  Pending 124 hours after death.

Funeral Director: All leted filled in by the fu ∃'Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my calculations. Medical сопретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month. Day, Year) 330 30,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cator 200 7+1 (3 Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7:16 PM 001030 i 28 Nov 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Agnes Social Security Number HOSPita Ballinoou 9 Birthplace (State or Foreign last birthday, Date of Birth (Month, Day, **Funeral** 1 M 2 □ F Days Months Alabama Director 11, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be retified at 1 Wes 2 □ No Director more W 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: à 3 Widowed 4 Divorced ack Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene: Important: If Item 27 is marked other than "na any injury or other traumatic event, the Modinione. (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dinson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Son) Robinson Liberty Road linit 502 Buyna Oak, MD 21207 Charles 6800 20c Location - City or Town, State 20b. Place of Disposition (Name of ) cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State en mount Crematory 12/7/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service License 21216 . K.ML 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 days **Physician** Severe Sepul disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Ulsease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy CHARLE in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 → Onknown 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certificate has been si completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 ₩100 1 ☐ Yes 2 ☑ No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ■ Impatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No Certification: To ROBINS 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Nerra P24070 28 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD, 21229 900 Caton Ave, Agnes Hospital SANGITA VERMA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

DHMH 17 Rev 7/2009

Registrar

DEC 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard E. Rodney 1:30 PM 2010 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Encore At Turf Valley Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** <sup>Year)</sup> 1943 1 🕅 M 2 🗆 F Months Days Hours Month, Day, Director 216-44-1204 67 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21042 2535 Marriottsville Road 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Imped Forces?
No 1963 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", 1965 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea ones. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Store Merchandise Inventory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Marie Liebhardt James Edward Rodney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Paradise, Sister 2948 Rogers Avenue Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 12/04/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Stag Dementia disease or condition egr Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death been signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page, performed this certificate 1 Yes 2 No Yes 20 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 's after death.

al Director: After tled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andres alazar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Fune			5. Social Security Number 6. Se	ex. ☐ M 2 <b>X</b> F 7. Ag		ast birthday)	If Under 1	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth	g.	Birthplace (State Country)	_
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or ite			<ol> <li>Marital Status</li> <li>         ↓ Never Married 2 ☐ Married     </li> </ol>	Armed Forces?		ŀ	Yes, specify	Cuban	, Mexican	, Puerto F	Rican, etc.)		Black, V	Vhite, etc.	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit		Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	ner: On the basis of e	xamination	and/or invest	igation, in my	opinion	, death oc	curred at 1	the time, date a	and place	e, and due to	the cause(s) and m	anner stated.
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5			30. Name and address of person who c	ompleted cause of d	eath (Item	23a) (Type, P	rint)								
4			GOTI CHNNTNGH	AM. M.D.	764	1 050	ER DR	IVE	TC	าพรอ	N. MAF	RYLE	ND 8	21204	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Nov Nov Day 2010 Year Physician/ 11:05PM Martha J. Rooney 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riderwood Village Prince George Silver Spring 9. Birthplace (State or Foreign  $TN^{ountry)}$ Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 □ M 2 🛛 F 4-16-1922 88 413-12-8466 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗆 Yes 2 🔀 No Prince George Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3160 Gracefield Rd. 20904 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Midowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Robert Buffaloe Leona Pickard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Rooney-son 1905 Patricia Ct., Westminster, MD 21158 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place)
Gate of Heaven 1 Burial 2 Cremation 3 Removal from State 12-4-10 Silver Spring, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Hones 1. 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Disease unk Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 🗋 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗹 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time. date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) qause of death (Item 23a) (Type, Print) 30. Name and address of person who completed ľ 20904 3160 PERN Genne (TRAcetield

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a&b Per. Inf G910 12/15/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Richard Month Day Year November 0723 AM /Medical 27 Z 0/ C 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Johns Hopkins Byvitus Medical Cont Baltumine 8. Date of Birth (Month, Day, Year) (in 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace *(State or Foreign Country)* Maryland 7. Age (In yrs. last birthday) **Funeral** Hours 12XM 2□ F Months Days Min. 217-38-8224 70 Director 1940 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, if the Marilant Exp. nit at must be notified an anguistic or other traumatic event, if a Marilant Exp. nit at must be notified an angue. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2€No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Towerwood Court Funeral 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2 🛣 No Specify 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Marina Owner Marine/Boating 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Harold G. Rudolph Dorothy M. Bennett ပ 19a. Informant's Name/Relationship (Type Print)
Susan .Kopriva (Fiance) 19a Majing Address (Street and Number of Burd Route Number, Mix or Java Street and Number of Burdalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland yure of Fyneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUD disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 6876时 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ certificate has been s rector, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To ¥⊒ Yes 2 □ No 1 Inpatient After this 25 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

Re Funeral Director: After the further of 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10028687 Wovenner 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Hopking Degicer Neplial Confi 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 2 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 1 Month Physician/ 2010 2:40p Sarah Ann Reid Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. 9105 Allenswood Rd. Randallstown 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🔀 F Hours Min. 0271711926 Maryland Director 84 217-16-8900 Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d. Inside City Limits with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Randallstown MD Baltimore CO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 9105 Allenswood Rd. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify. If Yes, Give Specify: Completed 3 X Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry SocialSecurity 15 Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administration clerk vears permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other I any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alberta Scott Nathaniel Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allenswood Rd., Randallstown, MD 21133 Sandra Miller(daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Cem. 12/07/10 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph Home PA 140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nos disease or condition resulting in death) ning Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that in the cause of the ca Examine Due to for as a consequence of: attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Alo Other (specify) Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsv performed? Yes 21 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature a 29d. Date signed (Month, Day, Year) f person who completed cause of death (Item 23a) (Type, Print) and address 31. Date filed (Month, Day, Year) State

X DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02:12 AM Warren Leroy Spencer ecember 010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sinal Hospital of Baltimore Baltimone If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year Country) 1 XM 2 □ F Days Hours MD 84 Director 215-20-8760 0-14-1926 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No PA Adams New Oxford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 17350 380 Manor Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ρ 1 Yes 2 No Specify: White Completed 3 ▼ Widowed 4 □ Divorced Year or Dates. 44-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Leadman Industrial 11 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Robey Spencer Freda Zlemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 145 Liberty Street, Westminster, MD 21157 Ronnie Spencer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem. 12/2/10 22. Name and Address of Facility 4100 Jonestown Road 17109 Harrisburg, PA Auer Crem. Ser. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhagic Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): pertensive 18 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Malianant nding physician and use as the burial-transi Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 2 1 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the cast of my knowledge, cast innocurred at the time date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 1, 2010 J, MD D 66 130 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE EMILIAND, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 2 2010

DHMH 17 Rev 7/2009

Registrar

21215-0036

ーフロニヒ

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Zolo **Physician** November /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkies JayView Timore Medical If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 ☐ M 2 ☐ XF Hours 213-62-8297 57 Director 09/29/1953 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ∐Yes 2X No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7859 Rockburne Road U.S.A. 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify δ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ath and Mental Hygiene. 27 is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) B 18. Mother's Name (First, Middle, Maiden Surname) ၉ George M. Phillips Helen L. Keyes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important; if item 27 any injury or other tr. once. Christina Chambers 7859 Rockburne Rd., Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Science Care 12/1/10 Mar (Specify) 5 ☐ Other (Specify) Aurora, CO 21. Signature of Fur Ital Service Licensee 22. Name and Address of Facility 19301 E. 23rd Avenue Science Care Aurora, CO 80011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2☑No 2 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier D70967 November 29,2010 Raltimore, MD 21224

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-08974

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Soles		State of Maryland /	Department of Certificate of	of Health o <i>f Death</i>	n and	Mental F	lygiene	201	0 3773
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Charles C. Soles					2. Date of D	Reg. No. eath Day Year er 22, 2010	3. Time of Death
.\$		4a. Facility Name (if not institution, give street and number)				ocation of Deat		er 22, 2010 4c. County of	2316 hrs Death
Funeral		Union Memorial Hospital  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Baltimo If Under		If Under 24Hr	e la Date of l	2:b/1414/DD/VVVV	9. Birthplace (State or
Director		422-50-9900 ₩X <sub>M 2</sub> _F	68 <sub>YI</sub>	Months	Days	Hours Mir		31/42	S. Birthplace (State or Foreign Country)
any		Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Loca	ation					10d. Inside City Limits
land f show	ō	MD n/a	•	altimon	re C	ity			1 XXYes 2 No
or 28a-	Director	10e. Street and Number 1541 E. 29th Street		10f. Zip C		1218		10g. Citizen of What	Country?
with th ms 23a be notif	eral D	11. Marital Status 12. Was Decedent F	ver in U.S. 13. W	as Decedent	of Hispa	nic Origin? (S	pecify Yes or N	USA	American Indian, Black,
r death	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X	No If	Yes, specify (	Cuban, N	Mexican, Puerto	Rican, etc.)	White, e	tc.
ours afte	d by	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete.	leted) 16a. Decede	Yes 2XX	cupation	(Give kind of	work done	Specify:	Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show, injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	during r	nost of workin	ng life. De	O NOT use reti	ired)		truction
15-00 filed wit Hygien d other	Con	17. Father's Name (First, Middle, Last) Ralph Soles			18.			Maiden Sumame)	
2121 2121  Muld be 1  Mental  marke ic event	To Be	19a. Informant's Name/Relationship (Type, Print )	19b. Mailir	n Address (	Street at	Ocie		is mber, City or Town, S	V-1- 71- 0-4-1
MD nd 2 shc alth and sm 27 is		Alice Brown / Sister	1429	Ester	Cou	ırt, Riv	verdale		5-2154
lore, ages la attof He it: If ite		20a. Method of Disposition  1 Burial 2 Cremation 3XX Removal from State	20b. Place of Dispos crematory or of Zion Memo	sition (Name of ther place)	of cemet	ery,	Date /27/10	20c. Location - Cit	
altin rmit. P. spartme sportan jury or	H	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee VICTOR P.						Birmir	
M 링스트를 Physician		23a. Part I. Enter the disease, or complications that caused the	15th	of Eas	ŧ•F8	rt Aver	Funera nue, Ba	Home, Ir Itimore Ma	nc. aryland 21230
/Medical Examiner	- 1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cause)			ying, suc	ch as cardiac o	r respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
***		or condition resulting in death)  Due to (or as a consequ							
	iner	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause	ience of):		-				
isit sa	≣∣	Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseque	ence of):						+
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760, icate be physical the burn	/Med	F FEMALE: 23c. If yes, outcome of	of pregnancy			_		23d. Date of deli	verv
x 68 th certification transfer as	sician/Medical	Bb. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at tim	e of death	tal death her (Specify)	3E	Ectopic pregnar	ncy	Month	Day Year
that the deat red by the att	£L	Yes 2 No 9 Unknown 9 Unknown  art II. Other significant conditions contributing to death but	0.						
P. P. Sthall	ত্র	art II. Other significant conditions contributing to death bu	it not resulting in the u	nderlying cau	ise given	in Part I.			to the cause of death?  Probably 4  Unknown
ords, aw requir as been s	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
Record The la							1 Yes	med? death	
Vital F system: this certifi	To Be	5. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient	2 Z ER/Outpatient		Othe	eath (Check of		Residence 6 Ot	h
n of ding Ph		7. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of In	ijury 28c.	Injury at	Work?		now injury occurred	ner:
Division  Division  ours after death.  teral Director: Affilled in by the fi	catio	Pending Investigation	- At home, farm, stree			2 No	of Landon (f		
Divis	Certification:	Homicide determined (Specify)	- Actionio, laim, cocc	i, ractory, onn	Se bunun	ng, etc.	28f. Location (S or Town, S		Rural Route Number, City
0 - 11 - 21	ल्ल	Ja. Certifier 1 Certifying Physician: To the best of my kni cre) 2 Medical Examiner: On the basis of examina	owledge, death occurr	ed at the time on, in my opin	, date ar	nd place, and d	lue to the cause	e(s) and manner as s	tated.
To wit	2	and manner stated.			ense nur			29d. Date signed (A	
		Edury, a	1)	Ο.	C.M.E.			November 23,	2010
	30	Name and address of person who completed cause of death Zabiullah Ali, M.D. Assistant Medical Exam		Street, B	altimor	re, MD 212	01		
Stat Registra		. Date filed (Month, Day, Year) 32. Registrar's S		Kas			·		

**Physician** /Medical Examiner executed Box 68760. that the death certificate be P.0. Records, Physiclan: The Vital of Division Hospital or Attending

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

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permit. Pages 1 Department of H Important: If Ite any Injury or ot

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certificate

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72 hours after

altimore, Maryland 21215-0036

10a. State Director 10e. Street and Number 634 Douglas Street Funeral 1 Never Married 2 Married à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) Be Edward ပ္ 19a. Informant's Name/Relationship (Type. Print) Mrs. Edonna Smith / Wife 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a yellow service cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Left Humerus Fracture 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No Medical Certification: To 27. Manner Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending subject fell fd 11-23-10 8:30 p. M 1 ☐ Yes 2 TNo investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 305 College Pkwy. 4 ☐ Homicide Arnold, MD. Nursing Home 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 50725 11-29-2010 rais Hwy Millersulle MD 2/108

State Registrar

State Registrar

31. Date filed (Month, Day,

0

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

EUTAW ST

SUITE 301. BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17perFH, G910, 12/2/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER DANIEL JOSEPH SIEGEL Medical 2010 06:434a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11 STREAM CROSSING ROAD
Security Number 6. Sex 7. Ag BALTIMORE BALTIMORE **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 F 215-25-3923 Days Hours 22 Min. 08/09/1988 **Director** MD Usual Residence of Decedent Show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 28a-f BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 7511 STREAM CROSSING ROAD USA 21209 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1XX Never Married 2 ☐ Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT STUDENT Be Exter's Name (First, Middle, Last)
EVERTT 18. Mother's Name (First, Middle, Maiden Surname, ည SIEGEL JANET BERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVERETT SIEGEL/FATHER 7511 STREAM CROSSING ROAD, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE HEBREW CEM.: 11/28/2010 4 Donation 5 Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Live 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Glioblastoma Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the ar 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 PResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Sembodie Dimau November 27,2010 D0068532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Himani Shishodis 1400 William Street, Baltimose MD 21230 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 2010 Janice Marie Short 11:57 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1917 Chipper Drive Edgewood Harford Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, March I 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 21x F Days Hours West Virginia Director 216-52-6007 60 Yrs 1950 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Harford 1 Yes 2X No Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1917 Chipper Drive 21040 United States Permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other treasment. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2x No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) <u>ll Years</u> Beautician Cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Charles T. Angle Phyllis Ann Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel M. Boston (Daughter) 3926 Glenhurst Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/30/2010 4 Donation 5 Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Dundalk, Maryland Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the dealth Do not enter the mode of dying, such as cardia or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons lu Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature and title of cer 29d, Date signed (Month, Day, Year, Name and add who completed cause of death (Item 23a) (Type, Print) 308 Bus 32. Registrar State Registrar

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who

ANTHONY KHU
31. Date filed (Month, Day, Year)

DEC 0 2 2010

EASTERN AVE

BALTIMORE MD 21224

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Schmidl TTT November 2010 10:39 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7857 East Baltimore Street Baltimore N/A 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Ye January 1, 1 🗆 XM 2 🗆 F Months Days Hours Director 214-64-5923 47 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7857 East Baltimore Street 21224 USA 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 years Asbestosis Removal Be Page 1 and 2 should be filed in ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Schmidl Jr. Dorothy Brashears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Victoria Sanders sister 716 Primson Avenue, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 Durial 2 X Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 1, Baltimore, Maryland 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md or complications that caused the dea 23a. Part 1. Enter the disea th. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown affer death.

• Director: Affer this certificate has been signed by t d in by the funeral director, page 2 should be detact d in by the funeral director, page 2. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: 은 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

only one)

29b. Signature and title of certifier

31. Date filed (Mont Day, Year)

2 2010

Baltimore

Mem. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Toung J. Lee 3001 5. Hanover St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ North FLORETTA 11 LL MAN 1959 2010 Medical **Examiner** 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Battinine 6. Sex If Under 1 Year If Under 24 Hrs. 8, Date of Birth Months Days Hours Min. Month, Day 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthd) 1 - M 2 7 F **Director** Yrs. Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No more 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life.,DO NOT use retired) during most of working Elementary/Ceconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licent Name and Address of Facility atel Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final OVER 5 UR Physician/ TROL UNC ERTEN NO. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** OBACC squartially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed OBESIT OVER 104RS that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav Year sate has been signed by the page 2 should be detached 9 Unknown  $-f(\lambda\chi + D)M(E)$ Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 \sum Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending iniury 1 Yes 2 No Accident Investigation within 24 hours after deal To the Funeral Director; Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medipal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a of ce 29c. License number SICIAN 9014 2010 of poson who completed cause of death (Item 23a) (Type, Print) 100 WASHIN CITON 31. Date filed Month, Day, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

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DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death **BALT IMORE** JAMES HOWARD LANE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NY **Funeral** 8. Date of Birth 02/02/1930 1 🗆 M 2 🌠 F Months Days Hours Min 214-22-2306 80 Director Usual Residence of Decedent show 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD **BALTIMORE BALTIMORE** 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21208 9230 JAMES HOWARD LANE USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes XX No Specify Specify: WHITE Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RECEPT IONIST CHIZUK AMUNO CONG. is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည **JACOB** SCHWARTZ **EDITH** WEINER traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 i permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr HARRIET DORMER/DAUGHTER 3304 MORELAND PLACE, BOWIE, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ARTICEN STONY CEMETER) CHIZUR AMUNO CONG. 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/30/2010 BALTIMORE, MD of Funeral Sen 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. El....r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? certificate I Yes 2 No 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 🕅 Residence 6 🗌 Other (Specify) 27, Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider (Month, Day, Year) 5 Pending Accident Investigation M 1 Tyes 2 🗆 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe

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State

and address of person

2

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ,2010 27 Taylor Sr Nov. 5pm Medical George 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>Future Care</u> Homewood Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Jan 16, 1918 Days 1 □**x**M 2 □ F Months Hours Min Director 215-05-782 92 Va Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified MD n/a Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 807 22nd St. Ε. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ MNo Specify. Completed 3 Widowed 4 Divorced Specify. Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3rd Bethlehem Steel Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Taylor Malinda Neal or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and : Department of Healt Important: If item 2 any injury or other t 1105 E. Rose Thomas/daughter Belvedere Ave. Balto. Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Dec.3,2010 ArbutusMem.Park Baltimore, Md 21. Sig ature of Funeral Service Licenses 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for se a consequence of: the attending physician and ched for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 😇 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav Year 2 🗌 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas performed After this certificate 1 Yes 25. Was case referred medical Be 26. Place of Death (Check only one) -2 No Other 1 Tes |은 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Man of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signatur and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 3

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 37750

		1- For State Registrar	Ce	rtificate of	Death	Re	eg. No.	0 01700
Physici		Decedent's Name (First, Middl	e,Last)	VA 1 *	11 ° 4	2. Date of Dear	th Day Year	3. Time of Death
Medical Exam	ıner	LC3116	YVETTE	VVI	lb. City, Town, or Location of D	November	<u> </u>	1040 hrs
		4a. Facility Name (if not institutio 822 N. Carey Street	i, give street and number)	eam	4c. County of De	1		
Funeral		Social Security Number	6. Sex 7. Age (In yrs. I	last birthday)	If Under 1 Year   If Under 24	4Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9./	Birthplace (State or Foreign
Director		200 70 5000	1 M 2 F 4	Yrs.		Min.		Country)
		Usual Residence of Decedent	1 N 2 1	113.		17tugus7	15,1969 11	narylana
any		10a. State 10b. County	10c. City,	, Town or Locati	on			10d. Inside City Limits
Maryland 28a-f show d at once.	ō	Mb		Ba	Itimore.			1 V Yes 2 No
Maryl. 28a-f d at o	Director	10e. Street and Number	<u> </u>		10f. Zip Code	1	0g. Citizen of What Co	ountry?
with the Maryland ns 23a or 28a-f sho be notified at once		1822 N.	Carey Stre	et	2121	7	u	SA
th with	Funeral	11 Marital Status 1 Never Married 2 Ma	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was	s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	<ul> <li>14. Race - Am White, etc</li> </ul>	erican Indian, Black,
or dear	Fur		1 Yes 2 No		$\dashv$	,		Link
0036 within 72 hours after death with the Maryland jene ter than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	þ		orced If Yes, Give Year or Dates: cify only highest grade completed)		Yes 2 No specify: 's Usual Occupation (Give kind	of work done	Specify:	) lack
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		est of working life. DO NOT use			,
036 ithin ne. r thar	μ	12	$\circ$		Operator		MT	A
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle,			18.Mother's Na	ame (First, Middle, N	~	-
21215-0036 hould be filed within 72 hours after the Mental Hygiene. is marked other than "natural", tic event, the Medical Examiner.	o Be	Winston	D. Williams		Aud		. Kusse	
	Ĕ	19a. Informant's Name/Relations	10.63.41.5	19b. Mailing	Address (Street and Number	2 1	nber, City or Town, Sta	ate, Zip Code)
e, MI 1 and 2 s Health a item 27		20a. Method of Disposition	Williams 20b. F	Place of Disposi	tion (Name of centery,	Balto.	20c. Location - City	or Town, State
2 2 2 2 2			The inoval from State	crematory or oth	er place)	2/6/2010	DUL	00 1
[ 6 를 급 · · · · 글.		4 Donation 5 Other Sp 21. Signature of Funeral Service			emetery ame and Address of Facility	-	DAITO	. Ma.
Balt permit. Depart Import		Oden se	Hran	2.2	Joseph L. Ku	Ave F	rai Home, Balto M	
Physician		23a. Part I Enter the disease, or failure. List only one cause	complications that caused the death.				est, shock, or Heart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	a. Artery	rrhythmi	a Due To Anoma	alous Righ	nt Coronar	y Death
ZXG/IIIIGI		or condition resulting in death)	Due to (or as a consequence of	f):				
	ē	Sequentially list conditions, if any leading to immediate	b. Due to (or as a consequence of	r)·				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c	,				
nsit ied	Exa	events resulting in death) Last	Due to (or as a consequence of	f):				
760, icate be executed physician and the burial - transit	cal	X UNPENDED	AMENDED 20b per	fh, 23	a,27 per me g9	12 2-2-11	vt	
60, ate be ohysicia te buria	Medical	IF FEMALE:	23c. If yes, outcome of pregr				23d. Date of delive	Prv .
587 srtifica fing p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	al death 3 Ectopic pre	gnancy	Month	Day Year
Box 68's death certification attending	sician/	1 Yes 2 No 9 ✔ Unki	Pregnant at time of dea	ath 5 Oth	er (Specify)			
O. B. t the de by the ached f	Phy		ons contributing to death but not re	esulting in the un	nderlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
, P.O ires that t signed by	<u>S</u>	S	•	g	,g g			obably 4 🗸 Unknown
ords, w require is been si should b	Completed					24a. Was a		autopsy findings available
COT	힐					autops	med? death?	
tal Rection: The certificate ector, page		25. Was case referred to medical			26.Place of Death (Che	1 Yes 2	2 No 1 🗸	Yes 2 No
Vita ysician his cer directo	Be C	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient			Residence 6 🗸 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	2	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of In			now injury occurred	
ion tendir or: A	흹	1 X Natural 5 Pendi 2 Accident Invest			1 Yes 2 No			
Divis pital or At ours after d eral Direct filled in by	ij			ome, farm, street	, factory, office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Spital sours a filled	Certification:	4 Homicide determ	mined (Specify)			Or Town, St	late)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans			ysician: To the best of my knowledg niner:On the basis of examination ar					
To the within To the comp	Medical	2 Medical Exam 29b. Signature and title of certifier	and manner stated.	nd/or investigatio	29c. License number	o at the time, date a		
	<	255. Signature and title of certifier	D. 00.		O.C.M.E.		29d. Date signed (M. November 29, 2	
		30 Name and address of porses	who completed cause of death (Item	23a)	J.J.W.L.			
		Patricia Aronica-Pollak		•	111 Penn Street, Baltim	ore, MD 21201		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re .				
Regist		DEC 0.2	2010   🗷	A. Ma	. Man II			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-09100 State of Maryland / Department of Health and Mental Hygiene John Thomas Whitaker, Jr. Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 27, 2010 hitaker. 1551 hrs **Medical Examiner** Thomas OhN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street end number **Baltimore** 4006 Dudley Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Country) Mary 19nd Director 218-74-9839 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Mary band perit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes 1 Yes 2 No specify: Give Year 3 Widowed 4 Divorced event, the Medical Examiner Þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joh NS John Thomas Be 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) injury or other traumatic Javin Whitaker 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mem rark Donation 5 Other Specify: re of Funeral Service Licensee alsen 7. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>о</u>. 1 Yes 2 No 3 Probably 4 Unknown <u>۾</u> Diabetes, Lipidemia, Wheelchair-bound Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? I∐Yes 2 ✔ No page certificate 26.Place of Death (Check only one) r this certific 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending within 24 hours after death. To the Funeral Director; completely filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number December 1, 2010 O.C.M.E. .00 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 28<sup>Day</sup> 2010 Year Physician/ 8:50 p M E. Willis Roger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Baltimore Cataloha Rd Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours MaV 16 . Day 935 229-38-3539 Virginia 75 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items on other trainmatic. 10a. State 10c. City, Town or Location 10d, Inside City Limits Funeral Director N/A 1 X Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5214 Catalpha 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 X Married Completed by Specify: White 1 ☐ Yes 2 🕱 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Thompson Richard Henry Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 5214 Catalpha Road Baltimore Maryland 21214 Kathleen Willis/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Mem. Gardens 12/3/10 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium Maryland Truneral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician metastatic months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) Firther Undoub Cause (Disease or iinjury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burner. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death
Unknown Month Dav Vear 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \( \sum \) Nursing Home 5 \( \begin{array}{c} \text{Residence} & 6 \sup \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D40850 Nivember 29,2010

Registrar
DHMH 17 Rev 7/2009

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State

Oftenano MB 9103 Franklin Squae Drive Baltimore Manyland 21237

d address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VOINC

31. Date filed (Month, Day, Year) DEC 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 30. 2010 11:00 A M Helen Lee Walter Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. | 11, 1920 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕞 F 220-09-0962 89 Mary Land Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 🗆 Yes 2 🔀 No Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral F 4102 Taylor Apt. 327 21236 U.S.A. Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. I **other than** " Elementary/Seconday (0-12) College (1-4 or 5+) Credit Clerk Retail Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental ပ Page 1 and 2 should be William Lee Minor Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Helen M. Sikorsky / Daughter 2833 Cub Hill Road Parkville, Md. 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🗔 Removal from State 4 Donation 5 Nother/Specify) Entombment Loudon Park Mauso. 12/3/10 Baltimore, Maryland 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complete. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ BRO disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 🗌 Yes 2 🗌 No Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 🗌 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
DEC 0 2 20 State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		artmen tificate			and M		giene Reg. Ne	2010	377	54
			Decedent's Name (First, Middle, La	ast)							2. Date of De	ath		3. Time of D	
	Physicia /Medic		Baby Brand	on Wills							Novem	ber	27,2010	18:0	9 M
п	Examin		4a. Facility Name (If not institution, given	,					Location o	f Death		40	c. County of Death		
			The Johns Hopkins H  5. Social Security Number  6.		e (In vre I	ast birthday)		more	-	24 Hrs T	8. Date of Birt	th.	I a Birth	nlace (State or	Foreign
T	Funeral Director			1 M 2 □ F	0	Yrs.	Months 2	Days 13	Hours	Min.	(Month, Da	v. Year)	1 0	place (State or antry)  MD	rureign
	TO		Usual Residence of Decedent					13			J-14-	-20	10		
	show	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City	
	he Ma 28a-f ptified	Director	MD Baltin	nore	Ec	lgemei						4- 01			
	sa or be n	ä	10e. Street and Number 2320 Ruth Ave				10f. Zip	1219	)			•	itizen of What Cou	ntry?	
	ms 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S	S. 13. \	Was Dece	dent of H	ispanic Orio	gin? (Spec	cify Yes or No-		SA 14. Race - Ameri	can Indian,	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healih and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 2 are notified at or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		f Yes, spe ¹ ☐ Yes		Specify:	, Puerto R	lican, etc.)		Black, White, Specify: Wh		
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and	2 should be f n and Mental H is marked of raumatic ever	o Be	Brandon Wills	•							lters	,	···,		
Z	should ind Men s marke umatic	၉	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Addres	s (Street	and Numbe	er or Rura	I Route Numb	er, City	or Town, State, Zi	p Code)	
Š	1 and 2: Health ai em 27 is other trau		Erin Walters -	- Mother		2320	Ru'	th A	ve.,	Edg	gemere	e, 1	MD 2121	9	
altimore,	es 1 a of Hei		20a. Method of Disposition 1	Removal from State	20b. P	lace of Dispo	sition (Na	me of other plac	(e) 1	2-4-	ate _10		Location - City or T		
<u>E</u>	Pages ment of ant: If ite ury or o		4 Donation 5 Other (Spec			cred	Hea:	rtic	of Je	us			ltimore	-	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee		PA	2. Name a	nd Addre 134	ss of Facilit	y Bra	adley- Spring	Asl J Ro	hton Fu bad, 21	neral 222	Home
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	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Heart	Fa	ilure								Onset and D	eauı
E	/Medical Examiner		resulting in death)	Due to (or as	a consequ	as marso	9 9		101 - 0						
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	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			· ·									
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9	ng ph e as t		IF FEMALE:	00- 16											
Box	ath ce ttendi for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Feta	I death 3	Ectopic		у			- 1	23d. Date of deli		əar
P.O.	the a	ysi	1  Yes 2 No 9 Unknown	9 Unknown	. time or de	eau 5	_ Other (St	Decity)							
s, G.	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transity.	by PI	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	underlying	cause gi	iven in Part	I.			use contribute to		
Division of Vital Records,	v requir been sig should	Completed									1 🗆		2No 3□Pro		nknown
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a E	siclan: The lay certificate has irector, page 2		05.14/								1 Yes	2 🗌 N		2 🗌 No	
<b>\rightarrow</b>	siclan certifi irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2	ER/Outpatien	+ 3 □ D(	OA Oth	ar.		(Check only o		6 ☐ Other (Spec	i6 d)	
o	Physer this eral d	일 ::	27. Manner of Death	28a. Date of Inju	ry	28b. Time o		28c. Injur	y at		28d. Describe			119)	
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Ω	Iltal or aff	Ce	One Consider	T. II.		1-1 1-1		1 - 1 41 - 12					· · · · · · · · · · · · · · · · · · ·		
	the Hospital or Attending Physician: the 2 hours after death. the Funeral Director; After this certifics mpletely filled in by the funeral director,	edical		hysician: To the best of the basis of aminer: On the basis of and manner st	f examinat										)
	To the Hospital or Attending Physician: The law within Fuh hours after death.  To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2	Mec	29b. Signature and title of certifier	and manner su	v d		29	c. Licens	e number			29d. D	ate signed (Month	, Day, Year)	
	F S F O		C Quinna	Eghnuta				DL	10ac	5/-		11/	27/2010	7	
			30. Name and address of person wh		death (Iter	n 23a) (Type,	Print)	20	01-	- 6			- 112010		
				GBUTA	1. 0:					600 N	lorth Wo	olfe	St, Baltimo	re, MD, 2	21287
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ture g. A	back	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILSON Varussa 2242 PM ovem ber 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A niversity of Mayland Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min. 1*6<sup>M</sup>/3*<sup>M</sup>77952 58 Maryland Director 220-64-8238 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1701 Eutaw Place Apt 624 21217 S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Arrington Laura unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chanel Johnson (daughter) 1168 Cleveland Street, Balto, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important; If ite
any injury or oti 1 🏝 Burial 2 □ Cremation 3 □ Removal from State Mt. Zion Cem. 12/3/10 4 Donation 5 Other (Specify) Baltimore, MD ature of Funeral Service Licensee 303899110dff.Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 ecquel Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Hupdolemia disease or condition 💃 Medical resulting in death) Due to (or as a consequence of) Examiner Digorhea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? 4 Pregnant 9 Unknown Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Diabetes Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 □ No ျာ 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? 1 Matural injury 5 Pending 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier NPI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merchant Street South recre 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death BARBARA Physician/ 1821 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMOR N/A LENTER MARYLAND MEDICAL UNIVERSITY OF 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2🏝 F Months Days Hours 08/28/1931 Maryland Director 79 216-32-3429 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD 21207 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3501 Howard Park ave. Apt212 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Care Giver Emerge Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Viola Thompson James E. Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1271 Cedar Croft Rd.,Baltimore,MD 21239 Janet Wise(daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date JosepherBrowner Fight And Crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ TYPE DISSECTION 10025 ADRTIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Unidenying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav Year 1 ☐ Yes 2 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? THORACO-ABDOMINAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a, Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: performed? Yes 2 No 2 🗆 No 1 Yes å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🖵 No ျှ 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital ( 24 hours a To the Hospital within 24 hours To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier P25666 MD lu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GFMARYLAND MEDILAL CENTER BALTIMORE, MD UNIVERSITY

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

	1 - For State Registrar		State of Ma	aryland		rtment of <i>tificate of</i>		Mental H	ygien Reg. ทั่		$\cap$	2775	
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/Medical Examiner		(If not institution, giv	re street and number)				or Location of Deal			c. County			
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Funeral	5. Social Security		Sex 7. Age	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth Da <i>y, Y</i> ea	r)	9. Birth	nplace (State or F untry)	
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DHMH 17 Rev 1/2001

DEC 0 2 2010 Server B. Spark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Day Year Physician/ MARY RITA **AMBROSETTI** 420 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square 8. Date of Birth (Month, Day, Year) 10-21-1921 . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Days Min. 212-12-0722 89 Hours PENNSYLVANIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits death w. h the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at a Director BALTIMORE MD ROSEDALE 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8610 McDANIEL AVENUE 21237 U.S.A. Fune Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc. Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hydiene. "natural", or want filem 27 is marked other than "natural", or ury or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates. WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 TITO MARY GRECO ( FRADO ) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANGELO AMBROSETTI/HUSBAND 8610 McDANIEL AVENUE ROSEDALE, 21237 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12-4-10 4 Donation 5 K Other (Specify) FNIOMEMENT BALTIMORE, CARDENS OF FAITH CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sinus Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 'oronan Sequentiary list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Pes 2 No Day Month Year Pregnant at time of death certificate has been signed by the irector, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗆 Yes 2 Accident
3 Suicide 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

C

21215-0036 Baltimore, Maryland bros Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Certificate: s after death.

I Director: Aft
d in by the fur 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D39758 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) Philacel Phia RO Suite 300 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29 Month Year 5 30 Physician/ PM Wendy Diane Allum 2010 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedale BalTimore FRANKLIN SQUARE HOSPITCH Center 8. Date of Birth (Month, Day, Nov. 13 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Year) 950 South Wales 1 □ M 2 🗶 F Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director United Kingdom 1 Yes 2 No West Yorkshire Llkiey 10f. Zip Code 10e. Street and Numbe 10a, Citizen of What Country? Funeral LS29 45 Wheatley Lane 8BW United Kingdom 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Elderly</u> Care Elderly Caretaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Moyra May Jenkins Leslle Gilbert Court 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45Wheatley Lane, Llkiey, United KingdomLS298BW David Allum 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State pton Crematory 12-7-10 4 Donation 5 Other (Specify) Skipton, England 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A michae 6009 Harford Road, Baltimore, Maryland21214 marcul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ embolism Pylmonary disease or condition Medical resulting in death) Due to (or as a consequenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-30-2010 RESODOO 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) FRANKLIN Square DR Balto Md 21237 dh 40 Adan ur chou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month // Year 2040 PM Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Westminster If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Ttaly (Month, Day, Year) 1 M 2 D F Months Hours Min. 122-48-0552 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No Sykesville MD Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21784 5207 Stone Mill Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Deceding Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White Specify: 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Residential Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Pasquale Carmela Martinelli Amodei 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5207 Stone Mill Ct., Sykesville, MD 21784 (Son) Mr. Pasquale Amodei 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery | 12/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Follore Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Due to (or as a consequence of). Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Year Yes 2 No this certificate has been signed by the all director, pare 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1  $\square$  Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; The 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital 2 M No 1 Yes 1 Nanpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury

Division of Vital Records, P.O. Box 68760

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Medical

State Registrar

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10059943

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 29,2010 102mber

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Uesminster Mio 295 Stoney

31. Date filed (Month. Day, Year 32. Registrar's Signature racke

5 Pending

3 29b. Signature and title of certifie

Investigation 6 Could not be

determined

Natural 2 Accident
3 Suicide
4 Homicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vovember Day **Physician** 1201 302010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) July 21,1952 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours M 2 🗆 F MD 58 July 216 58 0629 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County show or 28a-f shorn X Yes 2 □ No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö ral", or items 23a o Examiner must be 21205 USA 726 N.Linwood Ave. Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 I If Yes, Give X Year or Dates: Never Married 2 Married Black 21215-0036 1 ☐ Yes 2 X No Specify. \$ 3 Widowed 4 Divorced "natural". Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) Water Front the Laborer marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland s 1 and 2 should be fill f Heatth and Mental H tem 27 is marked oth Be Gilbert Addison Ruth Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 726 N. Linwood Ave. 21205 Karen L. Johnson-Bey (sister) Balto,Md. other permit. Pages 1 am Department of Heal Important: If item 2 any injury or other once. Baltimore, Dec. 2, 2010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Crematory Mount Balto,Md signature of Funeral Service Licensee 22. Name and Address of Facility alvin B. Scru Scruggs Funeral Home Meloune 213 Approximate Interval Between Onset and Death Preston St 1412 E Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ATICEAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner -1 xx hosis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: ase 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 🗌 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) d by the at detached f 2 🗌 No 9 Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? 2 2 No 26. Place of Death (Check only one Physiclan: 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 🗆 DOA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient ၉ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural
2 Accident 5 Pending investigation 1 Nes 2 No M al or Attend safter death filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 4 🗌 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number mo

State Registrar hy Scialla, mo Tonnec (10) 3 2010 32 diegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year AMES 0730 BROWN 20 11 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYDIEW CARE CENTER BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 216-22-3164 81 3-22-1929 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location MYes 2 ☐ No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2644 Aisqutih Street 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of workingn a life. DO NOT use retired) na Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Brown, Jr-Son 1113 E. Belvedere Avenue Balto, MD 21239 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-9-2010 Owings Mills, MD Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final putenscon disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) bleeding Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work?

hysician /Medical **Examiner** 

attending physician for use as the burial

the

signed by the

page certificate

director,

this After thi funeral c

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

that the death certificate be executed

Box 68760

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9.

Records,

of Vital

Division

The

**Physician** 

/Medical

Examiner

Director

Funeral

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Physician/Medical

by

Completed

Be

Certification: To

Medical

MD

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the "Modical Examiliar must be intiffied at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing, to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

1 Natural

2 Accident

4 - Homicide

3 ☐ Suicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28d. Describe how injury occurred 1 □Yes 2 □No

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

5 Pending

investigation

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number NPI# 1538365/68 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print).

JOHNS HOPEINS BAYBLEW CARE CENTER. 5505 HOLKINS BAYVIEW CIR BALTIMORE MA

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1032 PM 2016 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Bon Secours Hospital</u> Baltimore 8. Date of Birth (Month, Day, Year)
08 30 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign **X**□ M 2 □ F Country) Director 218-74-5922 Yrs. Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is amarked other than "natural", or items 23a or 28a-f sho any injury or other tranmatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 Stricker Street U.S.A. North Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na Security Security Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tulie Robinson <u>Raymond Rice</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21217 Stricker Street, Baltimore, <u> Marilvn Brunt-Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Cedar Hill 12/4/2010 Baltimore, Md 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av Ave 21215 Baltimore, Md 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Return erval Retween Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Cardervascular Orsease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obesites Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Tes 2 100 Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examine? Hospital Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. 1 Tes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined within 24 hours a To the Funeral C Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

RKES 2000 Wes 1 Buffimore STreet Baltimore Mo 2003 DONOVAN 32. Registra State

Registrar

10-09066 Bobby Ray Barnes

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.							
Physician/	Decedent's Name (First, Middle,		T			<ol><li>Date of Dea Month</li></ol>	Day Year	3. Time of Death
ledical Examine		Bobby Ray Ba					r 26, 2010	1028 hrs
	4a. Facility Name (if not institution, 610 Fairfax Avenue	give street and number)	41	o. City, Town, or L Brooklyn			4c. County of Anne Arur	ndel
Funeral Director		Sex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Min	,	7.00 mm/dd/yyyy) 19/1980	9. Birthplace (State or Foreign Country) New York
21215-0036  Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show any cevent, the Medical Examiner must be notified at once.  O Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10c. Street and Number  5654 Harbor  11. Marital Status  1	Valley Drive  12. Was Decedent Ever in Armed Forces? 1 Yes 2 No Note of Ity and Ity an	Baltimo  U.S. 13 Was frye  1 1 Shor  Thes, Sr.	Decedent of Hisps, specify Cuban, Yes 2 No s Usual Occupations of working life. It	Mexican, Puert- specify: on (Give kind of DO NOT use re COOk  8. Mother's Nam Ma: and Number or	pecify Yes or No o Rican, etc.) work done tired) e (First, Middle, rlize Ha	U.S.  14. Race - White, of Specify:  16b. Kind of Busin Restau  Maiden Surname) atfield mber, City or Town,	10d. Inside City Limits 1
Baltimore, MD  operation of Health and Department of Health and Important: If item 27 is injury or other traumating	Bobby R. Barne.  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spe  21. Si, ure Funeral Service A  23a. Part I. Enter the disease, or confailure. List only one cause of	3 Removal from State cify: certisee complications that caused the dec	b. Place of Disposis crematory or oth Cedar Hill 22. No. 400	ion (Name of cemer place)  11 Cemete ame and Address 01 Ritchi e mode of dying, s	etery, 12/ ery 12/ of Facility Go Le Highward as cardiac	Date O2/2010 Once Fun Vay Ba1 or respiratory ar	Baltimor eral Serv timore, M rest, shock, or head	rice, P.A. Maryland 21225
760, care be executed physician and the burial - transit the burial - transit		Due to (or as a consequence b.  Due to (or as a consequence c.  Due to (or as a consequence d.  AMENDED #1PerM	e of):	2/07/10 .	JH/ 23a	,27,28a	-f,perMEg	910 12/22/10 T
P.O. Box 68 es that the death certifiend by the attending or detached for use as 1 by Physician	Part II. Other significant condition	23c. If yes, outcome of print	regnancy 2 Fet f death 5 Oth	al death 3	Ectopic pregr	23e. Did t	23d. Date of di Month	Day Year  ute to the cause of death?  Probably 4  Unknown
Division of Vital I bispital or Attending Physician: hours after death. Inneral Director: After this certify filled in by the funeral director. Certification: To Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pendia 2 Accident Invest  3 ☒ Suicide 6 Could determ  29a Certifier	gation not be 28e. Place of Injury - A	28b. Time of Ir D Fd 10:2 At home, farm, streed	3 DOA Sijury 28c. Injury 28c. Injury 22am 1 You you to factory, office but dence	auto perful versione subjec alcoho or Town, Brook			
To the within To the comple	(Check only one) 2 Medical Exam  29b. Signature and title of certifier  30. Name and address of person of	iner: On the basis of examination and rianner stated.  who completed cause of death (I	an and/or investigat	29c. License O.C.M	death occurred number	at the time, date	e and place, and du	e to the cause(s)  d (Month, Day, Year)
o Kipend State	Victor Weedn MD JD  31. Date filed (Month, Day, Year)	Assistant Medical Example 32. Registrat's Sign		enn Street, B	altimore, Mi	21201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 45 Physician December baca 01 2010 Dennis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ₹M 2 □ F 207-42-9168 58 PA DEC 23, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County show aţ 1 ☐ Yes 2 ▼ No Director 7 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified VA Prince William Gainesville 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 20155 United States 7892 Virginia Oaks Drive Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 XYes 2 No 1969If Yes, Give 1973 1 Never Married 2 Married Maryland 21215-0036 1∐Yes 2∐XNo Specify: þ 3 Widowed 4 Divorced Caucasian Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) U.S. Postal Service Executive h and Mental Hygiel 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Margaret T. Comini Baca Anthony J. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau 7892 Virginia Oaks Dr., Gainesville, VA 20155 Carol A. Brooker / wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 [X Cremation 3 ☐ Removal from State Fairfax Memorial FH :12/04/2010 Fairfax, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Fairfax Memorial Funeral Home 9902 Braddock Road, Fairfax, VA 22032 M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Drain disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and d for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No detached i 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be det þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has performed 2 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) To the Hospital or Attending Physician: funeral director, Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No М 24 hours after death. Funeral Director; Al 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 December of 2010

State Registrar

Parson 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010 knewa

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 0130 2010 JAMES ROBERT BOLLINGER, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign Country)
MD. 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** 1 **X** M 2 □ F Months 219-30-7170 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 72 hours after death with the Maryland Director Baltimore County Baltimore Maryland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21224 8019 Eastdale Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter Armed Force Black, White, etc 1 Never Married 2 Married Yes 2 X No Completed by Maryland 21215-0036 White 1 Yes 2XXNo Specify: 3√ Widowed 4 □ Divorced Year or Dates and Mental Hygiene.

is marked other than "naturraumatic event, the Medical" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Bethlehem STeel N/A 18. Mother's Name (First, Middle, Maiden Surname) be filed 17. Father's Name (First, Middle, Last) Nora Bergins William Bollinger permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12028 Gores Mill Rd. Reisterstown. Md. James R. <u>Bollinger, Jr.</u> (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 12-3-2010 Baltimore, Md. Zion Church Cem 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd.Balto. Md. MOSES! Lassahn Funeral Home Approximate 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and use as the burial-tran that initiated events resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 Unknown Bivision of Vital Records, Completed ous runeral Director; After this certificate has been si completed filled in by the funeral director, page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed; No I or Attending Physician: The law after death.
Director: After this certificate has b 1 Yes 2 No 26. Place of Death (Check only one) 25 Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatlent 3 DOA ည 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending М 2 Accident 3 Suicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tit 2 30. Name and addres

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30, 2010 Physician/ 3:30 P. M Patricia Ann Baker November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Phoenix 10 Sunnyview Drive 9. Birthplace (State or Foreign Balt, Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** (Month, Day, February Days Hours 1 □ M 2**X**XF Months 52 Yrs. 1958 216-66-7524 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Phoenix Baltimore Maryland 10f. Zip Code United States of America 10e. Street and Number Funeral 21131 10 Sunnyview Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by white 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry e Elementary/Seconday (0-12) College (1-4 or 5+) Retail Cashier 12 Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Dorothy A. Debus Carroll E. Joynes, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 184 Ferring Court Abingdon, Maryland 21009 Karen A. Swain/ sister 20c. Location - City or Town, State December 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 4 Donation 5 Other (Specify) 4, 2010 Parkville, Maryland 21. Signature of Fundal Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MELANOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a detached f 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed h ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed been significant 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has but director, page 2 sh autopsy performed Yes 2 2 🗆 No the Hospital or Attending Physician: The 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ည within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Cortifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar GARY COURT NO

31. Date filed (Month, Day, Year)

01-081-000

65-69 N. CHARLET ST.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ C Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASON'S HOSPICE BALTIMORE CO RANDALLSTOWN 7. Age (In yrs. last birthday, 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MAY 22 MARYLAND 1 □ M 2 XX Months Hours 1955 Director 213-64-5551 Usual Residence of Decedent 23a or 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No MARYLAND BALTIMORE N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2441 SHIRLEY AVENUE 21215 U.S.A or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK "natural", 3 X XVidowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTH CARE 9th grade NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev STERLING HENRY PARROTTE LESSIE DAMERONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21215 Lessie Parrotte/Mother Shirley AVe., Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XX Burial 2 Cremation 3 Removal from State 4 Dogration 5 Other (Specify) ZION BAPT CHURCH 11-27-10 LOTTSBURG, VIRGINIA 21. Sig re of Funeral Service Agen Name and Address of Facility
LLIAM C BROWN COMM
106 W NORTH AVENUE, 206 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 234. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 № 3 ☐ Probably 4 ☐ Unknown Completed cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 😾 atural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

🛠 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Tay, 2010 8:55 P Physician/ December David Jav Berline Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchrist If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 D F 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Hours 7/31th/13444r) I Thois 345-36-5525 66 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland by Funeral Director 1 ☐ Yes 2√x No Towson Maryland | Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21286 23 Goucher Woods Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Spice Company Production Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Thomas Darrell Berline t. Page 1 and 2 should by thrent of Health and Merchant. If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Sheffer Goucher Woods Court Towson, Maryland 21286 Department of Health Important: If item 27 any injury or other the 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 12/3/2010 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Lolan Lancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending physic for use as the b IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal death☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? cate has 1 Yes certificate ! 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Land Dt1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:30 P Cephas Sandra 5010 November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Season's Hospice 5. Social Security Number 6. Sex <u>Baltimore</u> Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 XF Months Hours Director 58 09 217-54-1040 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be material. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Pikesville Baltimore MD 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A 21208 Kahn Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed <u>llth grade</u> Unemployed na Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Robert Thorne Berlean Barber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 704 Kahn Drive, Pikesville, Md <u>Deborah Thorne Ruffin-Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/7/2010 Baltimore, Md 21. Sig Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Luna cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown Day cate has been signed by the atte page 2 should be detached for Month Year 4 Pregnant Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed 1 🗌 Yes 2 🔲 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, 2 🗹 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

State Registrar 29a. Certifier (Check

29b. Signature and title of certifier

MSRy updhseM. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rajapak St., M.D. 2835 Smith NV - 5-203 Balthmore, MD. 21209.

32. Registrar Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOUS7465

29d. Date signed (Month, Day, Year)

12/1/10

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (if not institution, give street and number) **Examiner** SAMARITA TIMOR 8. Date of Birth 9. Birthplace (State or Foreign (In yrs. last birthday) If Under 1 Year **Funeral** 1 1/17 74 934 MARY IAND Days Min. 1 ★ M 2 □ F 76 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at with the Maryland Director Examiner must be notified 1 Xes 2 No IND 10g, Citizen of What Country? 10e. Street and Number ō by Funeral items 23a 21239 U.S.A Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces? 4/1953
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. ō 1 Never Married 2 Married 1 🗆 Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: BLACK 3 Widowed 4 Divorced Year or Dates. 5//955 "natural" Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) GENERAL MOTORS 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ CARTER COSEVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212/6 Health tem 27 JACKSON MARULAND DAUGHTER BALTIMORE, KAREN Department of Healt Important: If item 2 any injury or other or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10/2010 OWINGS MILLS, MARYLAND 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) DARRISON FOREST LEME DERRICK C. JONES FIH, PAI 21. Signature of Funeral Service Licensee The BALTIMORE, MARY land 21215 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** DIABETES Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and ned for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 🗌 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an HYPERTENSION autopsy performed? Yes 2 No ARTERY DISEASE 1 ☐ Yes 2 ☐ No CORGNARY 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA မ after death. Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by th 28f. Location (Street and Number or Rural Route Number, Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-D28987 29-2010 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) BALTO

State Registrar SPERLING, M.D

31 Date filed (Month, Day, Year)

LOCH RAVEN BLID

5601

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🔭 F Maryland 218 16 8204 88 09/03/1922 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show the Medical Examiner must be notified at Anne Arundel Glen Burnie 1 ☐ Yes 2 XNo Director Maryland 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 7422 Baltimore Annapolis Blvd. 21061 U.S.A. filed within 72 hours after death the Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 □ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Office Administer Proctor & Gamble permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, <u>it</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Namé (First, Middle, Last) Be Thomas Moore Sarah Bradshaw 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7422 Baltimore Annapolis Blvd. Glen Burnie, MD 21061 Norris Crockett / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 12/06/2010 Baltimore, Maryland 4 Donation 5 Dother (Specify) Cedar Hill Cemetery 21. Signatur of F neral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760€ Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 s performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Trighting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar DHMH 17 Rev 1/2001

State

10

29b. Signature and titl

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

N

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical Name (if not institution, give street and **Examiner** 4b. Cit√. Town, or Location of Death 4c. County of Death 8. Date of Birt Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F **Director** or 28a-f shov 10b. County Examiner must be notified at 10d. Inside City Limits Director timore 1 Yes 2 No town 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be ginee. Funeral USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Slack Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) fe. DO NOT use retired) onday (0-12) College (1-4 or 5+) Be ဂ္ 312 20b. Place of Disposition (Name of cometery, crematory or other) 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 ☐ Other (specify) Month Pregnant at time of death Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been of completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? May Was an perform 1 🗌 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending injury Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one leted cause of death (Item 23a) (Type, Print 30. Name and address of person who cor 31. Date filed (Month, Day, Year) State Registrar

# Baltimore, Maryland 21215-0036

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	-	artment ertificate			Mental Hy	giene .Reg. No.			
	Discontact		Registrar  1. Decedent's Name (Fixst, Middle, La	st)					2. Date of De	10	Year	3. Time of D	eath +
1	Physici /Medio	al	EUNICE	DEALE		de Die T		cation of Death	11	20		1240	P M
	Examin	er	Facility Name (If not institution, give Center's APA	a street and number)		4b. City, 7	lato	M S		(4)	Varle	2	
	Funeral		Social Security Number     6. 3	ex 7. Age ( □ M 2 1 F 8	(In yrs. last birthday	) If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bi (Month, D July 7,	rth ay, Year) 192	Co	hplace (State or i	Foreign
	Director		578-30-4604 Usual Residence of Decedent		₹				July 7,	192	I VI.	rginia	
	larylan show ed at	ō	10a. State 10b. County	1	Oc. City, Town or L							10d. Inside City 1 ☐ Yes 2	
	r 28a-f	Director	MD Charles  10e. Street and Number		La Plata	10f. Zip 0	Code			10g. Cit	izen of What Co	untry?	
	ath with 23a o ust be		One Magnolia Dr	ive			646				SA		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eventh Armed Forces? 1 □ Yes 25 No If Yes, Give Year or Dates:	er in U.S. 13.	. Was Decede If Yes, specif 1 ☐ Yes 22		anic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, White Specify:		
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pu	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last	)			18.		ne (First, Middle	e, Maiden	Surname)		
ıryla	should nd Mer marke imatic	은	Frank G. Kinsey  19a. Informant's Name/Relationship	Type, Print)	19b. Mai	lina Address (	Street and		Peyton  Iral Route Numi	ber, City o	or Town, State, 2	Zip Code)	
, Ma	and 2 sealth ar		Kim Kennedy - G	**	r   1802	1-н Кі	ngs P		r., Cor	_		28031	
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ıltim	permit. Pag D partment Important: I any injury c		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Services Lice			n Serv					risonbuı ral Home		
B	Day amy gang		Men B	endle		105 W.	Main	St.,	Front R	oya1	, VA		
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Vita	sician s certifi irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 □ ER/Outpatio	ant 2 🗆 DO	0.1		ath (Check only		6 Flother (0)	- 76. A	
ion of	nding Physician: The law ath. r: After this certificate has e funeral director, page 2 3	Certification: To	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day,			c. Injury at Work?		28d. Describe		6 ☐ Other (Spe ry occurred	icity)	
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certific	3 Suicide 6 Could not be determined		/ - At home, farm, s (Specify)	treet, factory,	office		28f. Location City or To	(Street ar own, State	nd Number or Re	ural Route Numb	er,
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	To the within To the complete	Me	29b. Signature and title of certifier	0.1		29c.	License nu	umber		29d. Da	ite signed (Mont	th, Day, Year)	
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	3		2007 Tidewood	s Colony!	Dr. Sui	RIA	A	moso	is mo	2 2	1401		
	Sta * Registi		31. Date filed (Month, Day, Year)	2010 32. Registrar	s Signature A.	park			1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 2 Physician/ 2010 226 AM Richard G. Deem Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harkord 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** Min. 1 🛛 M 2 🗆 F Months Davs Hours 2/3/1930 Country) Wisconsin Director 398-22-8642 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 √ Yes 2 □ No Havre de Grace MD Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 107 Wilfong Court 21078 Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11 Marital Status Armed Forces?

1 1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married White 1 ☐ Yes 2 🗓 No Specify: 3 🔀 Widowed 4 🗆 Divorced Completed Year or Dates. 1953-79 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Government Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ည Murtle Borchers Lou Linton Deem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07 Wilsong Court, Havre de Grace, MD 21078 Meg Deem (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Quantico Nat. Cemetery 12/8/2010 Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zcliman Funeral Home, P.A. ature of Funeral Service Licenses 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ temorrha disease or condition Medical resulting in death) Due to (or as a consequence 11: **Examiner** Ruptured Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Coagulopathy
Due to (or as a consequence of): attending physician and for use as the burial-trar anemia IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death the ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 Yes 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 2 🗌 No 1 Mnpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury Natural 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) D006542 Detember, 2, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Checapeake Drive, Bel Air, Maryland 21014

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC

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500

Fistler, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 02, 2010 12:00 PM MARY LOUISE DUSMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALT IMORE TOWSON CENTER SAINT JOSEPH MEDICAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 1 □ M 2 🙀 Days 220-22-6973 **Director** Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Harford Darlington 1 🗌 Yes 2 💢 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1806 Nobles Mill Rd 21034 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White Completed XX Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 yrs. <u>Medical Secretary</u> Dr. Bruce Rosenberg 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John George Class Cora Virginia Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara G. Connell (Daughter) 1806 Nobles Mill Rd. Darlington, Md. 21034 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 12-3-2010 Baltimore. Md . Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home assa Relair Rd Raltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ NEUMONIA disease or condition resulting in death) 2 DAYS Medical Examiner ELONEPHRITIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 A No Pregnant at time of death Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE PARKINSON 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate [ Yes 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and t 29c. License number D 52096

Registrar

DHMH 17 Rev 7/2009

State

7601 OSLER DRIVE

TOWSON

ause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

30. Name and address of person who completed

DAYID A. UTZSCHNEIDER.

			Please	Type or Pri AMEND IT State of M	nt in Black EM#10e,	ck Ir	delible In	k. En	sure A	Il Copie	S Are	e Legi	ible.		
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	Examin	er	4a. Facility Name (if not institution, give	street and number)			4b. City, Town, o				40	c. County of	of Death		
· promise.	Funeral		Manor Care Nurs 5. Social Security Number 6. Se	ex 7. Ag	e (In yrs. last birt	hday)	Ba If Under 1 Year		more ler 24 Hrs.	8. Date of Bi	rth		9 Rirthr	place (State or Forei	ian
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Baltimore,	permit. Page 1 and in Department of Healinportant: If item 2 any injury or other any injury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	20b. Place of cemeter	Dispos y, crem	ition (Name of atory or other plac	ce)	D	ate	20c, L	ocation - 0	City or To	wn, State	
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Division of Vital Records, P.O.	the Hospital or Attending Physician: The law requires that the death certificate be in 24 spiral or after death, the In 24 hours after death, the The conflicte has been signed by the attending physici mpleted filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director, page 2 should be detached for use as the but the but the funeral director.	Certificate;	4 Homicide determined	28e. Place of Inju- building, etc		m, stree	et, factory, office		2	8f. Location (8 City or Tov	Street and vn, State,	d Number )	or Rural	Route Number,	
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	the Ho lin 24 line Fu the Fu	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurse	ner: On the basis of ex	amination and/or	investi	gation, in my opinio	n, death	occurred at t	he time, date a	and place	and due t	to the cau	se(s) and manner sta	ated.
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	641		30. Name and address of person who co	L1 6 1	ath (Item 23a) (T	ype, Pri	nt) Do	مامنه	RA	land	Me	2 1	W	21234	
	State		31. Date filed (Month, Day, Year)	32. Regist a		3									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 Physician/ No VEMBE Year MABEL 4:40 FASTER LING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death INIVERSITY OF MARYLAND CENTER 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Yrs Director 219-32-8727 Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Glen Anne Arundel Burnie MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>310 Thelma Ave</u> 21061 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "! Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> Nurse na Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Carroll Wright Mable Blanding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Easterling-Son Thelma Ave, Glen Burnie, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/3/2010 Moreland Park Parkville, Md Signure of Funeral Service Licensee 22. Name and Address of Facility March F/H West 300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. x, or heart failure. List only one cause on each line. Approximate Interval Between mm Jate Cause (Final Physician METASTATIC se or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been mineral. attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown Part Ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No L Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 욘 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year)

State Registrar

STREE

BALTEMORE

MARYLAND

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

GREENE

32. Registrar's Signature

			Please	Type or Prin							.egible.	
			For State Registrar	State of Mai	,	epartme Certifica				Reg. No	010	37779
ſ	Physicia Medic		1. Decedent's Name (First, Middle, Last MARCARET	Ĺ	ED	WAR	DS		2. Date of Dea	Day 28	Year Zolo	3. Time of Death 2:05 AM
	Examir		4a. Facility Name (if not institution, give s  CASEY House	street and number)		4b. Ci		Location of Death			ounty of Death	omery
	Funeral Director		5. Social Security Number 6. Se:	X 7. Age (	In yrs. last birth	day) If Un Month	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day April I	h	9. Birthr	place (State or Foreign try)
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Baltimore,	0		20a. Method of Disposition  1		20b. Place of cemetery	, crematory c	or other place	ce)	Date 0/2010		tion - City or To $1$	
Baltii	permit. Page Department Important: I any injury or		21. Signature of Funeral Service License		00982			ss of Facility rall and ( Ave., Si				)910
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Box 68760	or Attending Physician: The law requires that the death certificate be executed affect death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at t 9  Unknown	Fetal death	3		су		230	d. Date of delive Month	ery Day Year
P.O.	that th	by Pr	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlyir	ng cause gi	ven in Part I.				ne cause of death?
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Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		4  Homicide determined	28e. Place of Injury building, etc.		m, street, tact	tory, office		28f. Location (S City or Tow		lumber or Rura	l Route Number,
	To the Hospital of within 24 hours af To the Funeral Discompleted filled it	Medical	(Check 2 Medical Examir	ician: To the best of m ner: On the basis of exa e Practioner: To the be	mination and/or	investigation,	in my opini	on, death occurred a	at the time, date a	nd place, ar	nd due to the ca	use(s) and manner stated.
	To the within To the complete	≥	29b. Signature and title of certifier	· C C C	ode of my knowne		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
0			30. Name and address of person who co	Y A	oth /Item 22a\ (T	ima Brint\	D3	7142		11-	28 -	2010
	10		GENEFREY COLEN	NAM MA	1355	Picci	ARD	DR #100	o Roci	KULLY	E MD	20850
	Sta Registr	te ar	31. Date filed (North, 2010)	32. Registrar	S Carlo							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Amend Item 24a per verb., g910,12/03/2010dhb.
Registrar 24a per verb., g910,12/03/2010dhb.
Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 28-2010 10:40 A M Morris Joshua Ensor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Elder Care Severna Park Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 MD Funeral 1 🛛 M 2 🗆 F 9 (M7nth 1 92 2 2ear) MD 214-14-5931 88 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 🗆 Yes 2 🔀 No Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 Coronet Drive 21090 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 X Widowed 4 ☐ Divorced white Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Mechanic Ith and Mental Hygien 27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joshua Ensor Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is 208 Coronet Dr., Linthicum, MD 21090 Linda Garner/daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o = 0 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 12/2/2010 Immanuel Cemetery Manchester, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 Signature of Funeral Se M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Dinset and Death Immediate Cause (Final Physician/ es tive Con disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown P.0. been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidney Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number

D 50725

29d. Date signed (Month, Day, Year)

11-30-200

use of death (Item 23a) (Type, Print)

28c 860 Veterons Hwy Millersville 40 21/08

Registpar's Signature. 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State DEC 0 3 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 559<sub>M</sub> 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nancy Lee Forwood 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or cation of Death Kosedale 40SDI tal Square If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🕱 F 73 Yrs. Feb 16, 217-34-5587 1937 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD Baltimore Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 United States 8063 Philadelphia Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Noyes Dorothy Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vicki Cox /Daughter 8063 Philadelphia Road Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 Removal from State Nov Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 22. Name and Address of Facility Funeral Alternatives 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ntracranial disease or condition resulting in death) Due to (or as a consequence of): pertension Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due w (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 12 No 2 1 NO 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) ther (Specify) urred

requires that the death certificate be executed Box 68760, P.O. Physician: ð

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The Funeral Director: A pletely filled it by the it. death.

the the

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

ral", or items 23a or 28a-f show

"natural"

Pages 1 and 2 should be filed within inent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "

event, It w Medical

Department of Heal Important: If Item 2 any Injury or other once.

**Physician** 

**Examiner** 

/Medical

death with

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Maryland 21215-0036

Baltimore,

-ORWOOD

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1 Yes 2 MNo	Hospital: 1 Inpatient 2 ER/Out	tpatient 3 □ DOA Other: 4 □ Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)
7. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Ir	Fime of njury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b determined		rm, street, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)
			e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
29b. Signature and title of de tifier		29c. License number	29d. Date signed (Month, Day. Year)

mpleted cause of death (Item 23a) (Type, Print) 9000

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 35/1-M Flowers Elizabeth K. DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON ANNE HRUNDEL MEDICAL ENTER GLEN BURNIE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Appust 30,1916 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland Funeral Months 1 □ M 2 🕱 F 213-09-2953 94 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. Counts death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dundalk Maryland 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 608 S. 46th Street 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 ▼ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ELIZABETH (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Tin Sorter Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I Giovanni Muraro should be Maria Menin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 215 McKeon Road, Severna Park, Maryland Doris Mazurkevich Page 1 and 2 4LOWERS Baltimore, Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dundalk, Maryland Sacred Heart of Jesus Cem any injury 4, 2010 . Signature of Funeral Service Licensee <sup>22</sup>. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death n signed by the at Id be detached fo 9 ☐ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed 124 hours after deatn. • Funeral Director: After this certificate I استعمار filled in by the funeral director, pag 2 No 2 Ľ 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5  $\square$  Pending Natural Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) me Buron 31. Date filed (Month, Day Year 32. Registrar State

DHMH 17 Rev 7/2009

Registrar

8:20 а.ш. NOVEMBER 28, 2010

THURLEY GAHS

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П	Physicia	n/	1. Decedent's Name (First, Middle	. ,						2. Date of De Month	ath Dav	y Year	3. Time of Dea	ith
	Media	al	THURLEY M. GA				T			NOV.	28 ′	<u> 2010                                   </u>	8:20A	M
	Examin	er	4a. Facility Name (if not institution STELLA MARIS	i, give street and number)			4b. City, Town,		of Death		4c.	County of Dea		
	Funeral		5. Social Security Number		ge (In yrs. las	st birthday)	If Under 1 Yea	rlf Unde	er 24 Hrs.	8. Date of Bir	th	g. Bi	rthplace (State or For	reign
	Director		178-24-0059	1 M 2 X F	80	Yrs.	Months Days	Hours	Min.	July 2	2,19	30   F	Buntry)	
	nd how at	=	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Lir	mits
	faryla Ba-f s tified	Director	Maryland Balti	more		Bal	timore (	County	/				1 ☐ Yes 2 🗓	Mo
	the N n or 28		10e. Street and Number		-		10f. Zip Code				10g. Citi	izen of What C	ountry?	
	n with	Funeral	4101 Martin AVe	enue				21236	3		U	SA		
	r death		11. Marital Status 1 ☐ Never Married 2 <b>X</b> ★ Mar	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Yes, specify Cul	Hispanic O ban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	ŀ	<ol> <li>Race - Am Black, Whi</li> </ol>		
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Be Completed by	3 ☐ Widowed 4 ☐ Divorced	If Van Cive A	X <sub>M</sub> o	1	☐ Yes 2 <b>X</b> XN	lo Specif	y:			Specify: Wh	nite	
20	hour 'natur	plete		nt's Education est grade completed)	T		ent's Usual Occu		st of worki	ina	16b. Ki	ind of Business	s Industry	
2	hin 72 ne. than '	mo	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DO	NOT use retired	d)	St OI WOIKI	ng .				
7	ed wit Hygie other	3e C	12th grade 17. Father's Name (First, Middle, I	I N/A		Но	usewife.	T 19 Mot	her's Name	e (First, Middle,		F-	ing-Own Ho	me
aŭ	be filed lental Hy rked oth ic event	2	Lloyd Buchter							Weber	Malderic	Surriame)		
Maryland 21215-0036	12 should buith and Me 27 is mark r traumatic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Stree	et and Numi	ber or Rura	al Route Numbe	r, City or	Town, State, Z	ip Code)	
	and 2 s Health a em 27 i		Lockered S. Gat	ns (Husband)		4101	Martin	Avenu	je Ba	<u>ltimore</u>	, Md	. 21236	6	
ore	ge 1 ag t of H if ite or oth		20a. Method of Disposition  1XX Burial 2 ☐ Cremation	3 Removal from State	cei	metery, crem	sition (Name of natory or other pl			Date		ocation - City o		
altimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		4 Donation 5 Other (		St.		's L.C.					timore		
Ba	permi Depar Impo any ir		21. Signature of Funeral Service	som C		<sup>22</sup>	. Name and Addi .assahn	Funer	al Ho	ma		elair F <u>ore, M</u> o		
			23a. Part 1. Enter the disease, or shock, or heart failure. List of			Do not ente	r the mode of dy	ing, such a	s cardiac c	or respiratory an	rest,		Approximate Interval Between	
park.	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a DEMENT				· · · •					Onset and Death	
	Examiner			Due to (or as	a conseque	ence of):								
		ner	Sequentially list conditions, if any, trading to immediate.	b. Due to or as	a conseque	ence of:								
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	с										
	rate be executed physician and the burial-transit	al E	resulting in death) Last	Due to (or as	a conseque	ence of):								
760	cate b physia the b	edical		d										
687	eath certifica attending pl	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of de	elivery	
Box	death certificate be executed he attending physician and ed for use as the burial-transi	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 <b>X</b> No	1 ☐ Live Birth 4 ☐ Pregnant a			Ectopic pregna Other (specify)	ncy				Month	Day Year	
P.O.	requires that the de been signed by the should be detached	Phy	9 Unknown  Part II. Other significant condition		out not resul	ting in the u	nderlying cause (	niven in Par	+ 1	22a Did to	oboooo u	aa aantrihuta t	o the cause of death	
o.	or Attending Physician: The law requires that the affar death affar death bincoor, Affar this cartificate has been signed by the by the funeral director, page 2 should be detach in by the funeral director, page 2.	d by	artii. Other significant conduct	Shis contributing to death t	odi noi resur	ang in the di	idenying eduse (	giverriiria		1 🗆	the state of the s	i	Probably 4 Unkr	
ğ	requii been should	ete								24a. Was			utopsy findings availa	
ဝင္ပ	hysician: The law I his certificate has b I director, page 2 s	Completed								autor	osy ormed?	prior to death?	completion of cause	of
<u>E</u>	an: Th tificat tor, pe	Be C	25. Was case referred to medical	-			26.	Place of De	ath (Check		2 <b>X</b> No	1 ⊔_Y€	es 2 No	_
₹	Physici this cer al direc	To B	examiner? 1  Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatien	t 3 🗆 DOA O1	ther: 4 🔲 I	Nursing Ho	me 5 Resid	dence 6	X Other (Spe	cify) HOSPICE	
101	ing Pl		27. Manner of Death  1   X Natural 5 □ Pendir	28a. Date of inju (Month, Da	ury 2 uy, Year) 2	28b. Time of injury		rk?	- 1	28d. Describe h	now injury	occurred		
Sio	ttend death stor: A the f	Certificate:		not be	un/ - At hom	o form stre		Yes 2		206 Leasties /	Name of the second	d Alumbay or D	ural Route Number,	_
Division of Vital Records,	al or A s after I Direc d in by	Cer	4 ∐ Homicide determ	building, et	c. (Specify)	io, iairii, sirc	ct, ractory, cinc		- 4	City or Tow			arai noute Number,	
\	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director, After this completed filled in by the funeral di	Medical	(Check 2 Medical E	Physician: To the best of Examiner: On the basis of	examination a	and/or investi	gation, in my opin	nion, death	occurred at	the time, date a	and place,	and due to the	cause(s) and manner	state
)	To the within To the Comp	2	29b. Signature and title of certifie	THE SIT PRINCIPLE OF THE	o control ling is	mountage, 2	1	se number	on sinc jour			e signed (Mon		
			14/10	NOS CANF			BI	49	192	_	Dece	ember 3	, 2010	
			30. Name and address of person											
	Stat	0	JACKIE JONES, 31. Date filed (Month, Day, Year)				LLEY RD.	TIM	IONIU	M, MD 2	1093			
	Registra			2010 / Juli	1	pa	Ked							
DUA	4U 47 Day 7/00	noa	DEC 1-1								-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ No Venber James Donald Gilson 20/D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday (Month, Day, Year) 2-29-1940 1 X M 2 □ F Hours Min. Michigan Director 215-36-7361 69 Usual Residence of Decedent or 28a-f show 10a, State 10b, County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Gambrills Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 2163 Davidsonville Road 21054 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 X Divorced White Year or Dates Baltimore, Maryland 21215-0 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Home Remodeling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Gilson Regina Vetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Walkinshaw / Cousin East Hamilton Lane Battle Creek, Michigan 49015 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 12-01-2010 W Odenton, Maryland 21. Sign ture of uneral Servic-Vicense 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, Maryland 21113 1411 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be executivitin 24 hours after death.

To the Funeral Director, After this certificate has been simple to the continuous to the continuous transfer. signed by the attending physician and dbe detached for use as the burial-trai Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🔲 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea . Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Public Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

of person who completed cause of death (Item 33a) (Type, Print)

3

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Man	yland / Depa	artment of H	lealth and	Mental Hy	giene	
		Registrar		Cer	tificate of L	Death		Reg. No. 20	0 3778
Physicia		1. Decedent's Name (First, Middle, L	_				2. Date of Dea	ath	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, gr	ve street and number)	ENU			Nou		Wa I/MAM
	٠.	3101 Hamilto	,		Balti	Location of Death	1	4c. County of D	eath
Funeral		Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h gi	Birthplace (State or Foreign
Director		217-07-7738 Usual Residence of Decedent	1 □ M 2 💢 F	90 Yrs.	Months Days	Hours Min.	(Month, Day	(, Year)	Country) Maryland
and show	o	10a. State 10b. County	10	c. City, Town or Loc	ation				
Maryk 28a-f	Director	MD		Baltimo	).To				10d. Inside City Limits  1 X Yes 2 No
h the a or 2	al Di	10e. Street and Number		Darcino	10f. Zip Code			10g. Citizen of What	
th wit ns 23 must	Funeral	3101 Hamilton			2121	4		United	States
or iter		<ul><li>11. Marital Status</li><li>1 \( \sum \) Never Married 2 \( \sum \) Married</li></ul>	12. Was Decedent Ever in Armed Forces?	in U.S. 13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - An	nerican Indian,
036 s afte	Completed by	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		☐ Yes 2 🗶 No		, , , , , , , , , , , , , , , , , , , ,	Black, Wh Specify:	
5-0	plet	15. Decedent's (Specify only highest of	Education	16a. Decede	nt's Usual Occupa	rtion		16b. Kind of Busines	White
121 thin 73 than	E	Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give ki.	nd of work done do NOT use retired)	uring most of work	ring	Tob. Kind of Busines	s industry
d 2	on h	12 17. Father's Name (First, Middle, Last)		Hom	emaker			Own Hor	ne
lan be file ental ked c	۱	Herbert Adams				18. Mother's Nam	e (First, Middle, M	faiden Sumame)	
Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exam	Ì	19a. Informant's Name/Relationship (	Type, Print)	10h Mailing	Address (Otens to	Mary	Vaine		
od 2 s alth a n 27 i	- [	David Greenwoo		T .				City or Town, State, Z	
Baltimore, bermit. Page 1 and Department of Hea mportant: If item my injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Domestal from State	Ob. Place of Disposit	tion (Name of tory or other place			20c. Location - City of	
timent trant: trant:		4 Donation 5 Other (Spec	ify)		d Cemeter		Dec 11, 2010	Parkvil	le, Maryland
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	21. Signature of Funeral Service Licen	see Mo					ernatives	,
	+	23a. Part 1. Enter the disease, or come shock, or heart failure. List only of	plications that assess the		8717 Gree	on Pactur	og Drive	Manage Man	yland 21286
Physician/		Immediate Cause (Final	one cause on each line.				-		Approximate Interval Between
Medical		disease or condition resulting in death)	a. <u> </u>	BICA-	$\subseteq \mathcal{D}$	nam	bose	7	Onset and Death
Examiner		Sequentially list annulting		ocquence on.					
xecuted al-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):					
and and trans	- 1	Cause (Disease or iinjury that initiated events resulting in death) Last	C				······································		
iar viri	3	oballing in death) East	Due to (or as a cons	sequence or):					
3760 ficate by g physic as the b	) L	= 7.	d						
ital Records, P.O. Box 687 idian: The law requires that the death certificate has been signed by the attending pector, page 2 should be detached for use as:  Be Completed by Physician/Mo	II   2	FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome of pred	gnancy				23d. Date of de	
Box death c he atten ed for us		in the past 12 months? 1 Yes 2 No	1 Live Birth 2 F 4 Pregnant at time 9 Unknown	-etal death 3 □ E of death 5 □ C	ctopic pregnancy other (specify)			Month	Day Year
P.O. that the ned by the detach	}	9 Unknown							
S, Presth resth signed at be d		art II. Other significant conditions of		resulting in the unde	erlying cause given	in Part I.		acco use contribute to	
of Vital Records,  g Physician: The law requires fer this certificate has been signeral director, page 2 should be te: To Be Completed I		percon		· · · · · · · · · · · · · · · · · · ·			1 L Yes	2 □ No 3 □ P	robably 4 Inknown
Recomplete has age 2	-						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
fital Resident The language of the certificate harector, page		. Was case referred to medical			OS Diagram		1 L Yes 2	No 1 Yes	2 🗆 No
Physici Physici this ce al direc	L	TE les 2 100	lospital:	☐ ER/Outpatient 3	Othory	of Death (Check		ce 6 Other (Speci	
ing P innera		. Manner of Death  1 Datural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	2	Bd. Describe how	injury occurred	<i>fy)</i>
Division of all or Attending P is a fler death.  al Director: After tad in by the funers in Certificate:		2 Accident Investigation 3 Suicide 6 Could not be			M 1 Tes	s 2 🗆 No			
DIVIS affect of in bine d in bine Cer		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street,	factory, office	2	Bf. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
the Hospita iin 24 hours he Funeral apleted filled	2	la. Certifier Certifying Phys	ician: To the best of my kno	owledge, death occu	red at the time, da	ite and place, and	due to the cause	(c) and mannar as at a	
		only one) 3 Certifying Nurs	er: On the basis of examinate Practioner: To the best of	tion and/or investigati my knowledge, death	ion, in my opinion, on occurred at the tin	death occurred at ti	ne time, date and pand due to the ca	place, and due to the c use(s) and manner as	ause(s) and manner stated.
No No No No No No No No No No No No No N	29	b. Signature and title of certifier	2/10)		29c. License nu			I. Date signed (Month,	
	-	1080	DUN		P/S	870	2 A	or sc.	2010
6	30	Name and address of person who co		em 23a) (Type, Print)	~ ~ 1/1	. /	2/1	21116	1
State	31	Date filed (Month, Day, Year)	32. Registrar's Sign	ture	1900	7	100	200	
Registrar		DEC 0 3 2010 A	see B. A	are					
DUMU 17 Day 7/0000									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of Maryla State Registrar		tificate of D			Reg. No.2	010	37786
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Year	3. Time of Death
	Medic	al	Ethel Maxine Gerva	is	T		Novembe		2010	1:33 PM
_)	Examin	er	4a. Facility Name (if not institution, give street and number)	27	4b. City, Town, or I				nty of Death Harfo	rd l
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. 2A s. last birthday)		If Under 24 Hrs.	8. Date of Birt	th	9. Birthp	place (State or Foreign
	Director		535 <b>-</b> 09-0121 1 M 2 🔀 F 96	Yrs.	Months Days	Hours Min.	Jan. 23	, 191 <u>4</u>	Wash	ington_
	nd how at	۲	Usual Residence of Decedent           10a. State         10b. County         10c. 0	City, Town or Loc	cation				1	0d. Inside City Limits
	faryla 8a-f s tified	Director	Maryland Harford A	Abingdon	1				İ	1 ☐ Yes 2 🔀 No
	the N		10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cour	itry?
	h with	Funeral	203 Star Pointe Ct. Apt.		21009			USA		
_	r deat or iten	by Fu	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ★ No	J.S. 13. V	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)		lace - Americ lack, White,	
3	s afte ral", c	q pa	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	Yes 2x No	Specify:		Spec	ify: Wh	ite
2-003p	2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	dent's Usual Occupa kind of work done du	tion uring most of worki	ng	16b. Kind of	Business Inc	dustry
121	thin 7 sne. than he Me	E S	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired)  1 Sales A	ssociate		Retai	1	
N O	led wi Hygie other ent, ti	Be	17. Father's Name (First, Middle, Last)	110001		18. Mother's Name	e (First, Middle,			
yland	d be fi dental arked tic ev	မ	Walter John Sievert			Ethel C	orinthi	a Andr	ews	
Man	should and I is ma	Ų	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street ar	nd Number or Rura	l Route Numbe	r, City or Town	, State, Zip C	Code)
e o`	and 2 s Health s tem 27 other tra		Floral Hills Funeral Home 20a Method of Disposition 20b	. Place of Dispos	Filbert R		nwood, l		n - City or To	sun Stata
o D	age 1 ant of litt. If its		1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State	cemetery, crem	natory or other place	)			-	ashington
baitimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Sip etule of Fundal Service Licensee		ills Cem. Name and Address MCCOMAS 1	12-3			ou, w	asimgton
ă	any Per	- 3	Hely M. Coman Elus		1317 Coke	esbury Ro	ad. Abi	ingdon.	Mary	land 21009
			23a. Part 1. Exter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.					rest,		Approximate Interval Between
^~ F	h sician/	9 7	Immediate Cause (Final disease or condition resulting in death)	5057	prtery	Dises	H			Onset and Death
	Medical Examiner		Due to (or as a conse	equence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter or or single Cause (Disease or linjury	equence of):			_			
7	uted nd ransit	Examiner	that initiated events							
,	e exection are urial-t	al E	resulting in death) Last Due to (or as a conse	equence of):						
09/90	icate be executed physician and s the burial-transit	edic	d							
000	certific nding use as	Physician/Medical	IF FEMALE: 23c. If yes, outcome of preg		7			23d.	Date of delive	ery
POX	death le atte	sicia	in the past 12 months?  1		Other (specify)	/			Month	Day Year
5.	at the d	Phy	9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not not not not not not not not not no	resulting in the u	inderlying cause give	en in Part I	230 Did to	phaceo use co	entribute to th	ne cause of death?
ν, Τ.	res the signed	d by	Takin Daloi digimidan Domanasi di dalam da da da da da da da da da da da da da							pably 4 Unknown
ğ	requii been should	lete					24a. Was	an 24		osy findings available
Vital Records,	he law te has age 2	Completed					autor perfo 1 🗆 Yes	rmed?	prior to condeath?	mpletion of cause of
<u>e</u>	ian; T		25. Was case referred to medical examiner?		26. Pla	ce of Death (Check	_	Z Be NO	1 1 103	2 110
5	hysic this ce al direc	မ	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2			4 ☐ Nursing Ho				)
0	ding P h. After 1 funera	Certificate:	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)	28b. Time of injury	work?	at Yes 2 □ No	28d. Describe h	ow injury occ	urred	
DIVISION OF	Attendrated deat	rtific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  28e. Place of Injury - At building sto Page			100 2 2 110			nber or Rural	Route Number,
<u>≥</u>	tal or, rs afte al Dire	S	building, etc. (Spec	oity)			City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier (Check (	tion and/or invest	tigation, in my opinior	n, death occurred at	the time, date a	ind place, and	due to the car	use(s) and manner stated.
	o the	Š	only one) 3 Certifying Nurse Practioner: To the best of 29b. Signature and title of certifier	my knowledge, o	29c, License	number		e cause(s) and 29d. Date sig		
	->-0		I Cho Am no		773	9889				26,2010
	5		30. Name and address of person who completed cause of death (It	em 23a) (Type, P	Print)	N 160				-
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Sig			· in		- 2		
	Registra		DEC 0 3 2010 Person D. 4	backer						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carol Lee Green Month 26. 2010 Medical November 6:02 A M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 616 Shore Drive Joppa Harford Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 🖾 F Days Director 217-44-4161 (Month, Day, Year) 66 Jan. 1944 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medic | Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27.5 is marked other than "natural", or items 23a or 28a-f sho any lifury or other traumatic event, the Medical Examiner must be norifized as 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince Georges Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 1009 Harrison Drive 20707 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \subseteq \text{Yes} \) 2 \( \subsetext{X} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. If Yes, Give 3 🔀 Widowed 4 🗌 Divorced 1 ☐ Yes 2 X No Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Food Servicer Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ျ Milton Howard Stebbing Mary Elizabeth Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Parsons/Daughter 14204 Phoenix Ave., Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-2-10 Hilltop Service Corp. Towson, Maryland Signature Fungral Service Licensee McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, M. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the most shock, or heart failure. List only on cause on each line. of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the bunal-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of deliven 3 Ectopic pregnancy Pregnant at time of death ed by the a detached f 1 Yes 2 5 Other (specify) Month Dav Year Part II Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be detent Certificate: To Be Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred **Grandquunter**Residence 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 3[ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Pearl Loretta Green 2ÖÎO 7:00a November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Ellicott City 2762 Old St. Johns Lane 7. Age (In yrs. last birthday) 79 Yrs. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD (Month, Day, 1 🗆 M 2 🗓 F 212-28-2517 1931 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Ellicott City 10b. County 10a. State 10d. Inside City Limits Director MD Howard 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21042 2762 Old St. Johns Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🏋 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine Edith Smith Joseph Leonard Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1230 Long Corner Rd., Mt. Airy, MD 21771 Regina Haughton (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 12-5-10 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee Paigrafaight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory aπest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Diab-to Onset and Death Immediate Cause (Final Physician/ disease or condition thown Medical resulting in death) Due to (or as a consequence of): Examiner ypertention unknown Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 MR Residence 6 Other (Specify) 1 \( \text{Yes} 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier

State
Registrar

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| State | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue | Continue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 20 JAMES GRIGSB Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie Baltimore Washinton Medical Center Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number 6. Sex 1 🌠 M 2 🗆 F May 8 Day, 1922 Director 206-12-2772 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2 🎇 No Anne Arundel Glen Burnie Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21061 7717 Baltimore Annapolis Boulevard 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No and Mental Hygiene. Specify: White 3 Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than College (1-4 or 5+) Sheet Metal Worker Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harrison Carrie John Henry Grigsby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linthicum Heights, MD 21090 308 Regency Circle Ms. Elizabeth Brusberg/executer injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot DEC 1 Burial 2 Cremation Removal from State 4 Donation 5 Other (Specify) Glenwood/shelby HI11 2010 Bristol, TN 21. Signature of Funeral Service U 22. Name and Address of Facility Singleton Funeral & Cremation Services pa 1 2nd Ave Sw Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SYNDROME disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death b**y**t not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cho 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏖 Unknown cate has been signated bage 2 should b Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No certificate 1  $\square$  Yes 25 Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

or Attending Physician: the Hospital

13+1

Medical

29a. Certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ce

City or Town, State)

30. Name and address of person who completed cause of death (I) em 23a) (Type, Print)

20 PHAM TRANG Date filed (Mo. nth, Day, Year) 3 2010 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine A. Gavin 3:45 A.M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min 05/25/1916 Country) Maryland 94 **Director** 218 01 6854 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mental Hygiene. narked other than "natural", or items 23a or atic event, the Medical Examiner must be r Funeral 21225 U.S.A. 326 Orchard Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Ď Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Maurice D. Clem Mary I. Larkins 27 is marked Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2.
Department of Health 8
Important: If item 27 Stephen Furbee / Grandson 3 Bogby Court Middle River, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 11/29/2010 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Gonce Funeral Service, P.A. Ritchie Highway Baltimore, Maryland 21225 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. set and Dea Immediate Cause (Final Physician/ disease or condition Medical resulting in death) s a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINE. cause. Enter Underlying the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and VINZE Due to (or as a consequence of): 0. Physician/Medical Dr. FOR Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 s autopsy certificate Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Department 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? ☐ Natural ☐ Accident injury 5 Pending FALLS SUBTECT HAD within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 1 No Investigation 6 Could not be Suicide Place of 'njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) C-LENBURME, HD ASSISTED FACILITY LIVING CRANBERRY COTTAGE, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 12009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) trois

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ JiB500 THONY 11 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner #102 Street llicholson Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Hours Min ろ 7.02.1957 WASH. Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No TSVIlle 10g. Citizen of What Country? 10e. Street and Number #102 SON 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0036 Black 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)\_ 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ruck injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Jordan 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
2017 Nic Holson St. #102 Hyartsville
20782 19a. Informant's Name/Relationship (Type, Print) (MOTHER) f Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Important: If Signature of Funeral Service Licensee any in Enter the disease, or complications that sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) on Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Certificate: To Be Completed by Physician/Medical 68760 the as IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Box Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy for Month Day Year detached 9 Unknown P.O. Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) LYON 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30, Physician/ NOVEMBER 2010 4:00 A M ESTHER CHRISTINE GOLDBERG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD ELLICOTT CITY SHANGRI-LA ASSISTED LIVING If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 DM 2 X Min 0271971921 Director 89 239-14-2026 NC Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Completed by Funeral Director items 23a or 28a-f 1 Yes 2 No MD HOWARD ELLICOTT CITY 10e. Street and Number 10g. Citizen of What Country? 4475 MONTGOMERY ROAD 21043 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō 1 Never Married 2 Married 2 XNo Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental F ဂ္ rmit. Page 1 and 2 should be I partment of Health and Ments portant: If item 27 is marked y injury or other traumatic e JOHN EDWARD BREEDLOVE **VENORA** MCKELDREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELODEE YATES/DAUGHTER 2716 WESTMINSTER ROAD, ELLICOTT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERANS CEM: 12/09/2010 OWINGS MILLS, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death the death. Do not enter the mode of dying. such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a cor Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Lemeral Director: After this certificate has been signed by the attending physicia the dilled in by the funeral director, page 2 should be detached for use as the burn and filled in by the funeral director, page 2 should be detached for use as the burn the purpose. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)
NO Vember 30 Th 2010 29b. Signature and title of ce

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUZUN ANCO, MD 5005 SYAY

32. Registrar's Signature

Type Print) Sell lane suite 202 Clarker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g911 1-5-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hurly Tracy A. Hurley December 2:25 AM Medical 2010 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death General Montgomery Hospital Olney Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □ F Months (Month, Day, Director 009-52-2408 Days Hours Min. 53 Country) Virginia Yrs Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3480 Queensborough Drive 20832 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ρ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 X Divorced White Specify: Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Stoughton Elementary/Seconday (0-12) College (1-4 or 5+) Teacher High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Spencer Runion Marjorie Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Demag - Daughter 351 Concord Street Glouster, MA 01930 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Prospect Cemetery 12/7/10 Epping, NH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stockbridge Funeral Home any Epping Road Exeter, New Hampshire 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic disease or condition resulting in death) pancreatic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, aun dic Examine cause (Disease or injury Due to (of as a consequence of). ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day 1 Yes 22 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 hrombocy Topenia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Coagulopalhy 24a. Was an certificate has autopsy perrormea? Yes 2 **X** Na 2 X No 1 Tes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 1 Tes 2 X No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury work? 1 Yes 2 No death. Accident Investigation Suicide 6 Could not be within 24 hours after or To the Funeral Direct completed filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vinh Bichhuma m 754996 Vecember 2010 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richhunna M. Dinh 18101 Prince F Philip 1) rive, Olney MI 20832 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December I 2010 10:22 A M Russel Stauffer Hackman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2525 Pot Spring Road Apt. L505 Timonium Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours Min. Director 184-12-6303 T916 Mastersonville, PA 94 Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🗶 No Timonium Maryland | Baltimore ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21093 2525 Pot Spring Road Apt. L505 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black. White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Broker Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Naomi Stauffer Jacob Zug Hackman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road Apt. L505 Timonium, MD 21093 Ruth B. Hackman/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/04/2010 |Gettysburg, PA Evergreen Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 00 9.6 5 disease or condition Medical resulting in death) Due to (or as a lonsequence of) Examiner Sequentially list conditions Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Division of Vital Records, 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? armia 24a. Was an NYONIC page 2 s autopsy performed After this certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 24 hours after death. 2 Accident
3 Suicide completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the basis of my line wilded death amount of the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year, ecember Name and address of person who co death (Item 23a) (Type, Print) Road anei 30

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ L. 2010 Agnes Haynes December 1:44 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months 1 M 2 X F Days 412-18-1671 Hours August 21, 1920 **Director** 90 Tennessee Usual Residence of Decedent show artment of Health and Mential Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location Director 10d. Inside City Limits N/A Maryland Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ā with 7005 Fait Avenue 21224 USA Funer 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc à 1 Never Married 2 Married 1 ☐ Yes 2 【XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic powers. 12 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Charles Fowler Nettie Nichols DECEMBER 1, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Haynes Husband 7005 Fait Avenue, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 Cremation 3 Removal from State Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 4, 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility I Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition END STAGE HEART DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? be detached for Pregnant at time of death Month Day Year the 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed page 2 should 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of autopsy performed? Yes 2 X No after death.

Director: After this certificate death? 1 Yes filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 2 🗆 No ☐ Accider☐ Suicide Accident Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signjed (Mjonth, Day, Year)

Registrar DHMH 17 Rev 7/2009

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State

2010

AGNES HAYNES

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

JONES.

31. Date filed (Month, Day, Year,

0 3 2010

CRNP

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TIMONIUM, MD 21093

Amend #26, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 29 2010 Timothy Stuart Ison November 9:00 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1427 Lowman St. Baltimore N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Hours Min. Jan. I. 1953 Director 216-62-2651 57 Marviand Usual Residence of Decedent show 10a. State 10b. County or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits 28a-f Marvland N/A Baltimore 1 XYes 2 No 10e, Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 1421 Decatur St. 21230 USA or items should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than ' Elementary/Seconday (0-12) College (1-4 or 5+) Computer Operator Insurance Company marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ William . Henderson Ison Lillian Wiesner 19a. Informant's Name/Relationship (Type, Print) S 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Melodye J. Culotta (Sister) 1427 Lowman St., Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) oudon Park Cemetery 12/3/10 Baltimore, Maryland 21. Signature of Funeral Service Licensul Name and Address of Facility Loudon Park Funeral Home any 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ Onset and Death disease or condition manusiue umanuelear Medical resulting in death) nsequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dish to for each polysecusines of Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed cate has been signated based and because of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate performed Yes 2 No 25. Was case referred to \_\_dical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 6 Xother (Specify) Sister's 4 \( \sum\_{\text{Nursing Home}} \) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Home 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No death. 24 hours after death completed filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) ROSENBERG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

			State	partment of Health and ertificate of Death	Mental Hygie	ene 0 1 0	37797
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	J. No.	
	Physicia		AUDREY VIRGINIA T	ONTE	Month	Day Year	3. Time of Death
, spinale .	Medi Examir		4a. Facility Name (if not institution, give street and number)	ONES  4b. City, Town, or Location of Death	NOVEMBER	27, 2010 4c. County of Dea	
The state of the s			HOLY CROSS HOSPITAL	SILVER SPRING	.	MONTGOM	
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	) If Under 1 Year If Under 24 Hrs.		9. Bir	thplace (State or Foreign
	Director		227-30-0119 0/ 11s.	Months Days Hours Min.	(Month, Day, Ye	1943 Vi	<sub>untry)</sub> rginia
pu	at	5	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
Aaryla	8a-f s tiffied	ect	MD Montgomery Sil	ver Spring			1 ☐ Yes 2 ☒ No
the	or 2	<u></u>	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	
with	IS 232	<b>Funeral Director</b>	10902 Oakwood Street	20901		USA	
death	item ner n	Ē	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
36 after	al", or Xami	d by	3 Widowed 4 Diversed If Yes, Give	1 ☐ Yes 2 🗓 No Specify:	Trican, etc.)	Black, White Specify: B	e, etc. 1ack
21215-0036 within 72 hours after death with the Maryland	atura ical E	Completed by	feat of Dates.	edent's Usual Occupation	l lea		
<b>215</b>	an "r Med	dmo	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	king	b. Kind of Business	Industry
Z #	ygien her th t, the		5+ Lib	rarian/Media	S	chool Sys	tem
and be filed	and Mental Hygie is marked other aumatic event, th	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maid	den Sumame)	
Marylal should be	d Mer mark natic	-	Lindsay Robinson Jones, Jr.		Washington	_	
2 %	Ith an 27 is traul	l la		ling Address (Street and Number or Rui )2  Oakwood  Street,			
<b>6</b> g			20a. Method of Disposition 20b. Place of Dis	position (Name of		c. Location - City or	20901
imo Page	Department of Important: If i any injury or once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cr	ematory or other place)		harlottes	
Balti permit. I	partr porta y inju ce.				. F. Bell	Funeral	Home
<b>o</b> ₹	2 = 6 8	1	Men Dlond l	108 6th St., NW, C			
			23a. Part 1 Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	sician/ /ledical	e V	Immediate Cause (Final disease or condition Metastatic Lung	Cancer			Onset and Death Yrs
	aminer		resulting in death)  Due to (or as a consequence of):				
4.0		Jer	Se uentially list conditions b. Liver Matastase buet fany, leading to immediate Due to (or as a consequence of):	5			Months
butted &	d ansit	amir	cause. Enter Underlying Cause (Disease or iinjury  Bone Metastases				Months
execu	an an rial-tra	EX	that initiated events c. Due to (or as a consequence of):				
box 68/60 death certificate be executed	ohysician and the burial-transit	dical Examine	d				
<b>687</b> Sertifica	ling p e as t	Me	IF FEMALE:				
Geath ce	attend for us	ian		Ectopic pregnancy		23d. Date of deli	1
Je de <b>u</b>	been signed by the attending p should be detached for use as t	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 g ☐ Unknown	Other (specify)		Month	Day Year
that t	deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
dS,	an sign	edt	COPD, Coronary Artery Disease		1 💢 Yes	2 🗆 No 3 🗆 Pr	obably 4 🗆 Unknown
N rec	2 sho	plet			24a. Was an	24b. Were aut	opsy findings available
VITAL RECORDS, lysician: The law requires	ate ha	Completed			autopsy performed 1  Yes 2	prior to c death?	ompletion of cause of 2 No
cian:	ertific ector,		25. Was case referred to medical examiner?	26. Place of Death (Check		THO TES	2 12 140
T V	this c	욘	1 Yes 2 No Hospital: 1 Hospital: 2 ER/Outpatie		ome 5 Residence	6 Other (Special	(y)
JIVISION OT al or Attending Pl s after death.	After	Certificate:	27. Manner of Death  1 Matural 5 Pending  28a. Date of injury (Month, Day, Year)  28b. Time of injury	work?	28d. Describe how in	jury occurred	
SIO Atten r deat	ctor:	ij	2	M 1 Yes 2 No	20f Leagting Atreat	and Number of Disc	- I Down to Marie I
al or	od in t		4 $\square$ Homicide determined building, etc. (Specify)	oot, motory, onloc	28f. Location (Street City or Town, Sta		ar Houte Number,
lospit 4 hour	uners ed fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time, date and place, an	d due to the cause(s)	and manner as stat	ed.
the F.	To the Funeral Director: After this certificate has been signed by th completed filled in by the funeral director, page 2 should be detach	— г	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at death occurred at the time, date and place	the time date and als	and due to the or	augo(a) and manner stated
P V	<b>6</b> 8		29b. Signature and title of certifier	29c. License number		Date signed (Month,	
			Durbaro Aupanich RSm, M.  30. Name and address of person who completed cause of death (Item 23a) (Type,		5	11/28/3	2010
	/O		Barbara Supanich Holy Cross Hospita	1500 Forest Cla	n Rd Sil	lver Spri	ag MD
	State		31. Date filed (Month, Day, Year)  DEC 0 3 201 02. Registrar's Signature	barker ofe	TTU 6 DT	rver phili	.6,
	Registra	r	DEC 03 2010 Lenens P.	7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20b Per FH G911 1/03/2011 JH

Amend Item 26 per verb., g910,12/03/2010dhb

Certificate of Death

Reg. No. 2 | | | | For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:55 AM W Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death -MOYE Funeral 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 X M 2 □ F Months Hours Min **Director** Country) Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced If Yes, Give Klack Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Deconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname) ည lsie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code, Street (Kaltimore 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 20th Place of Disposition (Name of Action of Polace) 20c. Location 12/30/2010 4 Donation 5 Other (Specify) Marulu 21. Signatur of Funeral Service Licens once, Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Coorcer Sequentially list of national Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical # 4の (Oe → スル Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Colamon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been a completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 2 🗸 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 Yes 2 4 Other: 6 Other (Specify Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 3. A Residence 27. Manner of Dea Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 \( \sum \) Yes 2 \( \sum \) No injury Accident Investigation Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 140, 2120 JIMJ TOMEN 31. Date filed (Month, Day, Year) State 32. Registrar's Signature **DEC 03** 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MICHAEL JOSEPH JONES, SR. PM Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE HOSPITAL HARFORD BEL AIR Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min. 1**X** M 2 □ F Hours APRIL 15, 1951 Director Yrs MARYLAND 215-54-1311 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD HARFORD ABINGDON 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 308 FULLERTON PLACE 21009 USA ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify. WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me gnoe. Elementary/Seconday (0-12) College (1-4 or 5+) WATERPROOFING CO. SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN T. JONES AGNES GEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY JONES-WIFE 308 FULLERTON PLACE ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 12/4/2010 BALTIMOR, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 6415 BELAIR ROAD BALTIMORE, MD 21206 Part 1) Enter the disease sheek, or heart failure. Les or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Ai completed filled in by the fu 1 Tyes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

fahent Known OS: Barbara Johnson
Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Ple	ase Type o							<b>All Copie</b> Mental Hy		•	gible.		
		For State Registrar			Of Ivial y			ate of			vieritai my	Reg. N	20	10	3	7800
Physicia Medi		1. Decedent's Nam	ne (First, Middl	. ,	ra Lee	Johns	on				2. Date of De		Day 24	Year 2010		Time of Death
Examir			tospita		<sub>Imber)</sub> Ihmo	ce	4b. (	1.1	or Location	on of Death	Ч	$\overline{}$	c. Count	of Death	h	
Funeral Director		5. Social Security N 219 50 Usual Residence of	7004	1 □ M 2 🗓 F	7. Age (In )	yrs. last birtho Yı	Mon	nder 1 Yea ths Days		der 24 Hrs. s Min.	8. Date of Bir (Month, De 07/15/	th 1 Year 1 94	8	9. Birti Mai	hplace intry ry1a	(State or Foreign and
/aryland Ba-f show tified at	ector	10a. State  Maryland	10b. County	I/A	100	c. City, Town o	r Location									side City Limits  Yes 2 No
with the Ns 23a or 2	Funeral Director	10e. Street and Nun		ad			10f	. Zip Code	 21216	<del></del>		10g. C	Citizen of			
2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Marr 3 ☒ Widowed		ried Armed F	s 2. █ No ive	n U.S.		ecedent of specify Cul			ecify Yes or No- Rican, etc.)			e - Amer ck, White		,
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be filed wit ental Hygie ked other ic event, th	To Be C	9th 17. Father's Name (	First, Middle, I	 Last) Raymon	d Geor		lomema oper	aker	18. Mo		e (First, Middle, velyn V		Surname	-/		availab1
nd 2 should salth and M n 27 is mar er traumat		19a. Informant's Na April M		hip (Type, Print) n / Daugh	ter			ress (Stree		nber or Rura	al Route Numbe	r, City c	or Town, S	state, Zip	Code)	d 21230
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disp 1  Burial 2 4  Donation	X Cremation	3 ☐ Removal from	01-1-	b. Place of D cemetery, Bayviev	crematory	or other nic	rce) <b>y</b>	i	Date 29/2010		ocation -	•	-	tate ryland
permit Depart Import any inj		21. Signature of Fur	neral Service L	scance	eve	Mr	22. Name	e and Addr	ess of Fac chie	Highw	nce Fun ay Ba1	era tim	1 Se ore,	rvic Mar	e, l yla:	P.A. nd 21225
Physician/ Medical Examiner	23a. Fart 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Approximate Interval Between Onset and Death  USCAS  Sequentially list conditions  Approximate Interval Between Onset and Death  USCAS  WASS															
te be executed nysician and ne burial-transit	dical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	imediate rlying iinjury	c		sequence of):	13522			_					7	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	_	F FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?		Birth 2 [	Fetal death	3	oic pregnan	су				23d. Dat	e of deliv	ery Day	Year
quires that i		Part II. Other signification	cant condition	ns contributing to a	death but not ケレ	resulting in the	ne underlyir	ng cause g	ven in Par VS-CA	ni. Se				_	/	se of death?
: The law re cate has be ; page 2 sh	Completed by							•			24a. Was a autop: perfor	sy med?	P	Vere auto rior to co eath?	mpletio	dings available on of cause of
hysician his certifi I director	10 B	25. Was case referred examiner?  1  Yes 2	No	Hospital:	Inpatient 2	☐ ER/Outpa	tient 3 🗆	Oth	or:	eath (Check Nursing Hor	only one) ne 5 ☐ Resido	ence 6	S ☐ Othe	r (Specify	·)	
tending P leath. tor: After t the funera	Certificate:	27. Manner of Death  1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investig 6 ☐ Could r	ation	of injury th, Day, Year,	28b. Time injur		28c. Injur worl 1 □	y at	2	8d. Describe ho					
pital or At burs after c eral Direct filled in by		4  Homicide	determi	ned 28e. Place buildi	ng, etc. (Spe						28f. Location (St City or Town	n, State,	)			Number,
o the Hos ifthin 24 hc o the Fune ompleted f	Med	29a. Certifier 1 (Check 2 (only one) 3 (29b. Signature and ti	Certifying	Physician: To the base kaminer: On the base Nurse Practioner:	sis of examina	ation and/or inv	estigation,	in my onini	on, death o	accurred at	the time, date an	d place	, and due	to the car	use(s) a	
2 3 4 8 4		▶ ane	rla	Watki	NS	D0				59			te signed MBC			
3		Mgc(a	Wat	vho completed caus Kens DC	se of death (It	tem 23a) (Type	e, Print) Be	Ivea	Like	Ave	Balh	mr	xe,	MD	2	1215
State Registra		1. Date lied (Month,	Day, Year)	32. R	egistrar's Sig	nature DANA										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12-01-2010 15:00 PM Suzanne Lawyer Kern /Medical 4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital 4c. County of Death Harford 4b. City, Town, or Location of Death Havre de Grace Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.6-24-1938 7. Age (In yrs. last birthday) 72 Yrs 5. Social Security Number 219.34-431 9. Birthplace (State or Foreign **Funeral** 1□M 2XF Yrs. Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Harford Havre de Grace 10e. Street and Number 10g, Citizen of What Country? United States of America 10f. Zip Code 126 Anderson Avenue 21078 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 💆 No Specify: 3 XWidowed 4 □ Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapist Health Care permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth ery lipity or other traumatic event 908. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Lawyer, Sr. Cora Bankert 19a. Informant's Name/Relationship (Typa, Print) LUANNE Miller (daughter) 19b, Mailing Address (Street and Number of Rural Route Number. City of Town, State Zip Code) 915 Barnett Lane, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Angel Hill Cemetery 12-04-2010 Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zerlman Funeral Home, F.A. 21018 21. Signature of Fundal 123 S. Washington St. Havre de Grace, Maryland 23a. Part1. Enter the desase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Urothelial **Physician** transitional Cell Carcinoma months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 246 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 4NO 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA erel Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) gause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

#### State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 30, 2010 12:09 AM Catherine Amelia Kogut Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, ) Days Hours 1 M 2 XF Months Maryland Yrs 1923 Nov. Director 217-14-2541 Usual Residence of Deceden 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits death with the Maryland Director must be notified 28a-f 1X Yes 2 ☐ No Maryland Harford Bel Air 10f. Zip Code 5 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 21014 USA 313 Linwood Avenue 0020 Am items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Medical Examiner Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. filed within 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Teresa May Ortt John Francis Welsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Malkus Way, Bel Air, MD 21014 Craig Kogut / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn. 12-4-10 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, N meral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tatic adeno concinana Immediate Cause (Final Physician/ Metus disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events <u>=</u> Due to for as a consequence on Exam the burial-transit Due to (or as a consequence of) resulting in death) Last MODOCOMPU Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month Month Day Year page 2 should be detached 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an OGUT, CATHERINE autopsy performed has usian 1 Yes 2 No Division of Vital director, 25. Was case r fe ed to medical 26. Place of Death (Check only one) To Be examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 27, Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 $\square$ Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) November 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 HESADEAKE DRIVE BELAIR MID 21014 500 UPPERC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Della Jean Keefer 3:00 P.M November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 162 W. Meadow Road Baltimore Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Days Hours Min. 0970871938 217 34 4540 72 Maryland **Director** Yrs. Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Anne Arundel Baltimore 1 Tes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 162 W. Meadow Road 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or δ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed 3 Widowed 4 XDivorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11th College (1-4 or 5+) and Mental Hygiene, is marked other tha Cashier Rite Aid traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be flik tment of Health and Mental tant: If item 27 is marked of ပ Lloyd Adkinson Clara E. Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Cade / Daughter 305 Norman Avenue Glen Burnie, Maryland 21060 : If item? 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 11/24/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part 1. Enter the disease complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death COPONAVY Physician/ disease or condition resulting in death) 16121 DUSCATE Medical Due to (or as a consuluence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 Tes Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 HNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

Division of Vital Records, P.O.

OHIWOW

1340

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiepen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth **Physician** Day Kunek Year 0105 November 30 1710 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FutureCare-Reisterstown
If Under 1 Year | If Under 24 Hrs. Cherrywood Baltimore 8. Date of Birth Mar 26, 1926 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 🖁 F Months 217-20-7186 Hours Min. 84 Maryland Director Usuaf Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow ury or other traumatic event, the Madical Examinat must be nutitied at 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits Md. 1 ☐ Yes 2 ☐ No Baltimore Perry Hall Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ll Beagle Run 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritaf Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No þ Specify: Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George J. Zinner Gertrude Hoesch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Kurek - Daughter 18 Austin Road Reisterstown, Md. 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Bayview Crematory 2, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician 1 Pars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of defivery in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 ☐ Yes 2 BNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospitaf: 1 ☐ Yes 2 ₺ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient this 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A М 1 TYes 2 □No illed in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the lime, date and place, and due to the dause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 November 30,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medis WY 5685 31. Date filed (Month, Day, Year) State 32/Registrar's Signature Registrar

		For State Registrar	Sta	ate of	f Marylaı	nd / Depa <i>Cer</i>	artmer <i>tificat</i>			and M	1ental Hy	giene Reg. No.	010	37805
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<b>Baltimore, Maryland 21215-0036</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Nancy Loane Yuill	nip (Type, Prin	t)	Dtr	19b. Mailin <b>760</b> B	g Address <b>Fairv</b> i	(Street ar	nd Numbe enue #	r or Rura	Route Numbe	r, City or To 21403	own, State, Zip	o Code)
<b>Saltimore,</b> Dermit. Page 1 and Department of Heal Important: If item: any Injury or other		20a. Method of Disposition  1 Durial XX Cremation	3 🗆 Remov	al from S	State	Place of Dispos cemetery, crem	sition (Nan atory or o	ne of ther place	)		Date	20c. Loc	ation - City or	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 4 5	Live B	ant at time of	al death 3 🗌	Ectopic p Other (sp					23	3d. Date of del Month	ivery Day Year
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I or Atten after deat Director:	Certificate:	3 Suicide 6 Could determ	not be		of Injury - At h	ome, farm, stre y)	et, factory	, office		2	28f. Location (S City or Tow		Number or Rur	al Route Number,
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To th within To th comp		29b. Signature and title of certifier			~//	1		License r		>1			signed (Month	7
3		30. Name and address of person v	who complete	d dause	of death (Iten	n 23a) (Type, Pr	int)	(, 4	MI	100	//	p.	Chan	# 2/3/2
State Registra		31. Date filed (Month, Day, Year) DEC 0 3 2010	Zeneva	32. Rec	strar's Signa	ture	<del>J. (</del>	<u> </u>		<i>-</i> 40_	)		- / - /	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2127M 2010 Medical **Examiner** cility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BUTNIE 6. Sex If Under 1 Year If Unde **Funeral** Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 □ M 2 🛛 F 434-92-9718 Hours Min. March Day Year) 195 Director 57 Loursiana Yrs Usual Residence of Decedent a or 28a-f show be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho arrivinty or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified a 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits LA Orleans New Orleans 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 6263 London Drive 70122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates, 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 X Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Lee Marion Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Lee-Watson 6069 Toomey La., Elkridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bagnell & Son
Crematory 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-30-10 Covington, LA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Professional Funeral Services 1620 Elysian Fields Ave., New Orleans, LA 70117 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Approximate Immediate Cause (Final disase or condition Interval Retween Physician/ Onset and Death LD distase or condition resulting in death) Medical Due to (or as a consequence of): Examiner scun fielly let no dillon, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month signed by the at d be detached for Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ 6 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Funeral Director: After this certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: 은 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending iniury 24 hours after death. Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar

2

Name and address of person who

31. Date filed (Month, Day, Year)

An

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merica

cause of death (Item 23a) (Type, Print)

ONRS

32. Registrar's Signature

10-09159 Ira Lynch

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 37807 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3 Time of Death Month Day November 29, 2010 0807 hrs Medical Examiner IRA Andre Lynch 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Northwest Hospital Randallstown **Baltimore County** 5, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Davs Hours Director XXM 2 F 365-82-8459 33 Yrs June 2, 1977 Michigan Usual Residence of Decedent iny 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes XX No 28a-f show "natural", or items 23a or 28a-f sho MD Baltimore Owings Mills death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9111 Thistledown Rd. Apt. 392 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Deco Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Pages I and 2 should be filed within 72 hours after death wintent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XX Never Married 2 Married 1 Yes B1ack 3 Widowed 4 Divorced If Yes, Give Year Specify: 1 Yes XX No specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Teacher/Administrator Charter School 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Robert J. Lynch Barbara Frost ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Lynch / Mother 22 Gray Street, Apt. C-4, Hartford, CT 06105 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Mothics of the received the Cemeter Crematory TXBurial 2 Cremation 3 Removal from State Windsor Bloomfield, 12/08/10 Important: injury or oth Other Specify. Donation 5 permit. Departm 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mi**11**s,MD2111<mark>7</mark> 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each line a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and X AMENDED 23a,27 per me g911 1-28-11 vt sician/Medical by the attending physician a ached for use as the burial -X UNPENDED #20a-c.perFH\_G910\_WS\_12/3/10 23c. If yes, outcome of pregnancy The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available autopsy prior to completion of cause of has b death? performed' page 1 Yes certificate ✓ Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural after death.

Director: / 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town State) within 24 hours a determined To the Hospital 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. etelv Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year) **OCMF** O.C.M.E. November 30, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

State Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 | 0

				tificate of Death	Reg. i	-2010	37809
	Physicia		1. Decedent's Name (First, Middle, Last)  Leonard Vernon Lassiter, Jr.		2. Date of Death Month	Day 70 Year	3. Time of Death
	Medio Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
	Funeral		Doctor's Community Hospita1  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Lanham  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince G	eorge's
	Director		242-80-9157 <sup>1</sup> M <sup>2</sup> □ F 59 Yrs.	Months Days Hours Min.	089637195	§1 Cou	ntryNC
	and show	ē	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Loc	ation			10d. Inside City Limits
	Maryl 28a-f ootified	Jirect	MD Prince George's Lanham		-		1 Yes 2 No
	with the 23a or	Funeral Director	10e. Street and Number 6412 97th Ave.	10f. Zip Code 20706	10g. US	Citizen of What Cou SA	untry?
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  Et if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: B1	
15-0	72 hou n <b>"nat</b> u Iedical	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation find of work done during most of working	16b.	. Kind of Business I	ndustry
212	within giene. er thar , the M		Elementary/Seconday (0-12) College (1-4 or 5+) Pasto	ONOT use retired) or/Minister	Re	eligion	
and	be filed intal Hy ced oth ced oth	To Be	17. Father's Name (First, Middle, Last) Leonard Vernon Lassiter, Sr.	18. Mother's Name Marian Ke	(First, Middle, Maide	n Surname)	
Baltimore, Maryland 21215-0036	should to and Me	3		g Address (Street and Number or Rural 97th Ave. Lanham,	Route Number, City	or Town, State, Zip	Code)
re,	1 and 2 of Health item 2 other t	3	20a. Method of Disposition 20b. Place of Dispos	sition (Name of		Location - City or 1	
timo	trant or tank		4 Donation 5 Other (Specify) Science			Phoenix,	
Ba	permit. Page Department Important: Il any injury or			Name and Address of Fackbapp I 33 Gist Ave. Silve			
7	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Do not enter that caused the death. Do not enter that caused the dea	the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Oriset and Death
8760	ificate be executed g physician and as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  b. Due to (or as a subsequence of):  c. Due to (or as a consequence of):	ny brief			
Box 6	death cert ne attendir ed for use	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deliv	very Day Year
, P.O.	law requires that the nas been signed by the e 2 should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to t	the cause of death?
Division of Vital Records,	w requi	Completed	Husechusm		24a. Was an	24b. Were auto	ppsy findings available
¥	The lar	Com	Higherland		autopsy performed?	death?	empletion of cause of
ıtal	sician: certific irector,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: I position 2  FD (2) the ship of the	26. Place of Death (Check of Other:			
0	ng Phy fter this ineral d	ite: To	1   Inpatient 2   ER/Outpatient  27. Manner of Death   Natural 5   Pending		ne 5 Residence 8d. Describe how inju		ý)
Sion	ottendii death. ctor: Ai y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Of Landian (Street e	and Number or Dum	J. Davida Alumbay
Š	tal or Ars after rs after al Director birector	4 Homicide determined building, etc. (Specify)	a, factory, office	8f. Location (Street a City or Town, Star		ii Houle Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investignable.  Medical Examiner: On the basis of examination and/or investignable.  Gertifying Nurse Practioner: To the best of my knowledge, death or 2 miles of the best of my knowledge, death or 3 miles of the best of my knowledge.	gation, in my opinion, death occurred at t	he time, date and place	ce, and due to the ca	ause(s) and manner stated.
	To the withing the configuration of the configurati	-	29b. Signature and title of pertifier	29 c. License number	29d. D	ate signed (Month,	
	10		30. Name and address of person who completed cause of death (item 23a) (Type, Pri	MDD16410		1/29/110	
	,		Gabriel B. Jaffe 8116 Good in	uck long suite	300, Lanh	AM, MD	20706
	Stat	е	31. Date filed (Month, Day, Year)  32. Registra's Signature				

			1 - For State Registrar	State of Ma	ıryland		artment d <i>tificate d</i>			Mental Hy	/gien Reg. N	201	0 3	7810
	Physicia	in/	1. Decedent's Name (First, Middle, Las Marian Brickle	,						2. Date of De Month	eath D	ay Year		ne of Death
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	Funeral Director		5. Social Security Number 6. S		(In yrs. last	birthday) Yrs.	If Under 1 Y		der 24 Hrs.	8. Date of Bi	ay, Year)		irthplace (State	ite or Foreign
land	show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	eation							e City Limits
Mary	28a-f otifie	Funeral Director	MD		Ва	ltimo	ore						1 🔀	Yes 2 □ No
th the	3a or t be n	al D	10e. Street and Number				10f. Zip Co	de			10g. C	itizen of What (	Country?	
ath wi	ms 2	nuel	830 W. 40th Str	eet Apt. 1		140.14		211	0.1-1-0.0	** Y		United		
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland	tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 2 Widowed 4 Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Dates,		If	Yes, specify (	Cuban, Mex	ican, Puert	oecify Yes or No- o Rican, etc.)		14. Race - Am Black, Wh Specify:		
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Maryland	nd Mental marked o	٩	William Willar	d Hunt				10. 101		ın Almina		,		
ary should	and N is ma auma		19a. Informant's Name/Relationship (7)	/pe, Print)		19b. Mailin	g Address (Str	eet and Nui		ral Route Numbe			ip Code)	
<b>7, ∑</b>	ealth m 27 ner tra		Sarah B Wolfende	n /Daughter		62	5 St. 3	Johns	Road	Baltimo	ore,	MD 212	10	_
<b>Baltimore,</b> permit. Page 1 and	it of H : If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 👺 Cremation 3 ☐	Removal from State	20b. Place ceme	e of Dispos etery, crem	sition (Name of atory or other	place)		Date Dec 02		ocation - City o	r Town, State	)
Iting	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licens				ake Cre			2010	-	Beltsvil	le, Ma	ryland
g a	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		Rebacca de la	cheiman	Mois	85 22.				neral Al				
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only o	olications that caused the cause on each line.			the mode of	dying, such	as cardiac	or respiratory ar	rest,	rson Mar	Approxi Interval	
) N	ysician,∘ Medical		disease or condition resulting in death)	a. Inters Due to (or as a	titial consequenc	ce of):	1 Dis	ease						nths
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<b>BOX 08</b> e death certifi	To the Farbous are used:  To the Farbous are used:  Completed filled in by the funeral director, page 2 should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal de	ath 3 🗌	Ectopic pregr Other (specify					23d. Date of d	elivery Day	Year
that the	ed by detac		Part II. Other significant conditions co	ntributing to death but	not resultin	ng in the un	derlying cause	given in Pa	art I.	23e. Did to	obacco	use contribute t	o the cause o	of death?
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VICAL IN	sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				. Place of D	Death (Chec					
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ording	: After	cate	1 Matural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day,		injury	l w	ork?	□No	28d. Describe h	iow injur	y occurred		
UIVISION OF all or Attending PI	Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined			farm, stree	et, factory, offic	ce		28f. Location (S City or Tow		d Number or Ru )	ıral Route Nu	mber,
Hospita	Funeral	Medical	(Check 2 L Medical Examination    (Check	ician: To the best of m	mination and	d/or investig	gation, in my or	inion, death	occurred a	t the time, date a	nd place	and due to the	cause(s) and	manner stated.
To the	<b>To the</b>	≥	only one) 3 $\square$ Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the be	ist of my kno	owieage, ae		ense numbe				s) and manner as te signed (Mont		
			I mum Re	7-MO			AT	2438	1946			ember :		0
	8	ļ	30. Name and address of person who co											
			Michael Pitzer  31. Date filed (Month, Day, Year)	102 South	Welfe	St., 1.	Baltima	re, A	10 21	23/				
	State Registra	_	Michael Pitzer 31. Date filed (Month, Day, Year)  NEC 0 3 2010	32. Registrar's	Signature	Ken								

DHMH 17 Rev 7/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year KATHERINE LEINBACH 7:25 A M NOVEMBER Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOHNS HODKENS BANGEU MEDEUAL CENTER Date of Bird. (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 KF Months Days Hours Director 90 373-18-8032 Michigan Usual Residence of Decedent or 28a-f shov Director 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "... any injury or other than "... Funeral 8134 N. Boundary Rd. United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify. 3 X Widowed 4 ☐ Divorced Completed Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Andrew Bretz Katherine Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Skipper /Daughter Doreen 8134 N. Boundary Rd. Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Dec 0.3 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland <u>Chesapeake Crematory</u> 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives MO 1585 10 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition DAYS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examiner Que to forms mod sequence of g physician and as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death Month Day Vear 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N this certificate 2 🗌 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical To the Funeral Director, After this certific completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending Investigation Could not be 1 Tes 2 No Accident M Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

(Check

29b. Signature and title of certifier

MARC LAROCHECLE 31. Date filed (Month, Day, Year

**DEC 0 3 2010** 

4940 EASTERN AVENUE BALTEMORE, MD

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a.M

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

NOVEMBER 30 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2010 Physician/ Month 2:20 A M Richard M. Lippert Nov. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 7368 Pershing Place Marriottsville Carrol If Under 1 Year 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. 1 🕅 M 2 🗀 F Hours (Month, Day, Ye 55 Director 214-68-0808 ept Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll 1 Tes 2 V No Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7368 Pershing Place 21104 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify Specify: 3 Widowed 4 V Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Consultant Utility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Edwin Lippert Rita Anne Mandato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rita A. Bonsall (Mother) Smeton Place Unit 303, Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/1/2010 Sykesville, MD View Mem. Park . Signatyne of Funeral Service Licen 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ pancien disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, Physician/Medical Examiner Due to jor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural 5 Pendina injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DayST Year Physician/ М 1-BITH LARMORE 0 DELEMBER 01 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Randallstown 4c. County of Death
Baltimore **Examiner** Northwest Hospital Center 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec 19 1938 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 耳 F 214-34-2618 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at rector MD Carroll Sykesville 1 Tes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 5409 Linton Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner r 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 - Widowed 4 X Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) registered nurse health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard Connolly Agnes Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ronie Shackelford (daughter) 903 Berrymans Ln., Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 12-6-10 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Dauge Haright D P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final Onset and Death Physician disease or condition HEUMONIP Medical resulting in death) Due to (or as a consequence of) Examiner KARETORO Sequentially list conditions, if any leading to in recist cause. Enter Underlying Examine and I-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician a use as the burial-1 Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?

1 Yes 2 No
9 Unknown Year 5 Other (specify) Month Day Pregnant at time of death the P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, METASTATIC SQUAMOUS CELL CARLINGMA 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a. Was an page 2 autopsy performed? Yes 2 N this certificate 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No ည 1 X Inpatient 2 - ER/Outpatient 3 - DOA After thi funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident iniury 5 Pending thin 24 hours after death.

the Funeral Director: At ompleted filled in by the fu 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete only one 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) mehta mo DECEMBER 015T 2126

DHMH 17 Rev 7/2009

State Registrar KTROPIL

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUSPITAL

32. Registrar's Signature

MEHTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Lea Main Nancy 2010 10:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7906 Kavanagh Road Baltimore Dundalk . Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗐 🖈 (Month, Day, Year) January 23, 1927 220-26-6148 Director Yrs Marvland Usual Residence of Decedent f show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Dundalk 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7906 Kavanagh Road 21222 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by 1 Never Married 2 Married Black. White, etc. Baltimore, Maryland 21215-0036 Yes 2 No of Health and Mental Hygiene. Item 27 is marked other than "natural", other traumatic event his hazarral", If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Supervisor Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clifford Babcock Elizabeth Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 New Castle Street, Gainesville, GA. Cynthia Sherrill Daughter 30507 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December ò 1 XBurial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Middle River, MD. 4, 2010 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death neumoni disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Unknown Month Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy within 24 hours after death.

To the Funeral Director: After this certificate performed' death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗆 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number

Registrar

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State

31. Date filed (Month, Day, Year)

2

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year William Matthews Medical <u>Fletcher</u> 2010 6:00a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3805 Bonner Road If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 🕅 M 2 🗆 F Hours Min. Country) Yrs **Director** 216-12-8778 88 21 MD items 23a or 28a-f show 10a. State filed within 72 hours after death with the Maryland **Funeral Director** 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Baltimore 1 Yes 2 No NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. <u>3805 Bonner Road</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic even" \*\*\* (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver 4th grade Trucking Company na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Cora Turpin <u>Linwood Matthews</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Matthews-Wife 3805 Bonner Road, Baltimore, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) 12/1/2010 Woodlawn, Md Memorial Park 21. Sign Runeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av 23a. Par 1. Enter the dit ease, or complications that caus 4 he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line.

Immediate Cause (Fina disease in condition resulting in death)

a. Due to (or each accession) Baltimore, Md Approximate Interval Between Onset and Death Physician/ weki Medical Due to (or as a consequence of): Examiner equer tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5/ Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier 1 Crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009

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29b. Signature

30. Name and

and title of certifier

address of person who completed cause of death (Item 23a) (Type, Print)

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32, Registra 's Signature

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License number

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 11:24 Marshall Vera Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 12, 1 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Hours Min. Virginia Director 578-28-2394 90 Yrs 1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f st must be notified a 1 Yes 2 X No Palmyra VA Fluvanna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1679 Rising Sun Road 22963 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Beautician ulth and Mental Hygie 27 is marked other r traumatic event, th Hair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Jackson Holland Mary Odie Brice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Karen M. Moore-Granddaughter 6714 Esslog St., Capitol Heights, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Holland Family Cemetery 1 A Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Dec.5,2010 Palmyra, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. F. Bell Funeral Home 108 6th St., NW, Charlottesville, VA 23a. Pff 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock or heart failure. List only one cause on each line. Approximate Interval Between ARRHVTHMIA disease or condition FATAL Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any leading to in reclaim cause. Enter Underlying Physician/Medical Examine Dissitti (oraș a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ဂ္ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury ☐ Accident ☐ Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and the of certifier

Registrar DHMH 17 Rev 7/2009

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Box

P.O.

Division of Vital

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32. Registrar' Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVIS.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** C. Mentzer Jean 11-23-2010 1940 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12-03-1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 221-12-2572 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showevent, the Madical Examination and the notified at Havre de Grace Maryland Harkord 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Weber Street 21078 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🛣 No à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Admunよいはひん 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Service is marked other Maryland 17. Father's Name (First, Middle, Last) Arthur C. Caponic 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental Laura M. Morrison traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. (Son) 3715 Green Spring Road, Havre de Grace, MD 21078 R. Davis Mentzer, Ir. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery: 11/27/2010 Havre de Grace, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. <u>123 S. Washington St., Havre de Grace, MD 21078</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown signed by <u>ت</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ✓No 24a. Was an autopsy certificate 2 No Vital 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division **Natura**i 5 ☐ Pending investigation n 24 hours after death.
ne Funeral Director: A 2 Accident 1 ☐ Yes 2 🗆 No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Alexander A. Siowbo M. 251 31. Date filed (Month, Day, 32. Registrar's Agnature State Year)

Registrar

DHMH 17 Rev 1/2001

			for State	of Maryland /				nd Me	ntal Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of E	eath			Reg. No.	2011	37818
	Physicia		Richard Hemsing Morriso	n				2	Date of Deal Month		Year	3. Time of Death
w.	Medi Examir		4a. Facility Name (if not institution, give street and nut			4b. City, Town, or	Location of	Death	11/23		County of Dea	9:20 P <sup>M</sup>
مر	<i>?</i>		Glade Valley Nursing Ho	me		Walker				1	rederi	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		If Under 1 Year Months Days	If Under 24		Date of Birt	th	9. Bi	irthplace (State or Foreign
	Director		Usual Residence of Decedent	81	Yrs.		, louio	IVIIII.	(Month, Da 12/09/	1928		MI
	and show	ō	10a. State 10b. County	10c. City, Tow	n or Loc	ation						10d. Inside City Limits
	Maryl 28a-f otifiec	Director	MD Frederick	Frede	rick							1 ☐ Yes 2 🗶 No
	h the	al D	10e. Street and Number			10f. Zip Code	_			10g. Citiz	en of What C	ountry?
	th with ms 23 must	ner	5435 Jefferson Pike			21703				Unite	ed Sta	tes
	r deal	y Fu	Armed Fo	edent Ever in U.S. prces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origir n, Mexican, F	n? (Specify Puerto Ric	Yes or No- an, etc.)	14	4. Race - Am-	
980	s afte ral", c Exan	d b	3 Widowed 4 Divorced If Yes, Girly Year or D	2 □ No ve 195i - 195	4	☐ Yes 2 🗖 No	Specify:			S	pecify: W	
2-0	hour natur dical	Completed by Funeral	15. Decedent's Education	16a		ent's Usual Occupa				16b. Kind	d of Business	Industry
2	nin 72 Je. Jhan ' e Me	шo	(Specify only highest grade completed Elementary/Seconday (0-12)  College (1		life. DC	ind of work done do NOT use retired)	uring most o	of working				ŕ
7	d with tygier ther t nt, th	Be C	5+		Cl <sub>e</sub>							Service
Maryland 21215-0036	oe file	일	17. Father's Name (First, Middle, Last)  Felix Casto Morrison				18. Mother's			Maiden Su	irname)	
2	ould by mark mark		19a. Informant's Name/Relationship (Type, Print)	140			Helen		sing			
Š	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Alwina Morrison- Wife	54	. Mailing 435	g Address (Street al Jeffersor	nd Numbero ı Pike	or Rural Ro Fred	ute Number lerick	City or To	own, State, Zi 21703	p Code)
altimore,	of Hear of Hear fitem rothe		20a. Method of Disposition	20b. Place o	f Dispos	ition (Name of	-	Date			ation - City or	Town State
Ĕ	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☑ Donation 5 ☐ Other (Specify)	State Unifor		story or other place Services			2010		•	MD
att	permit. Page 1 Department of Important: If i any injury or once.	ŀ	21. Signature of Funeral Service Licensee	M00382	_	Name and Address	_	_,,		Deene		lst Ave.20910
<u> </u>	9 9 <b>= 6 9</b>	1	Stolut Lolinian		Raj	op Funera	1 & C	remat	ion S	er.		Spring MD
			23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on ea	caused the death. Do rich line.	not enter	the mode of dying	, such as car	rdiac or re	spiratory arre	est,	_	Approximate Interval Between
- +	Trysician/	8 8	Immediate Cause (Final disease or condition	erebrovascu	ılar	Accident	_				1	Onset and Death
	Medical Examiner		resulting in death)  Due to	or as a consequence of	of);							
		er	Sequentially list conditions, b.	or as a consequence of	off:							
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)	be executed sician and burial-transi	EX	that initiated events c. Due to	or as a consequence of	of):							
9	cate be executed physician and s the burial-transit	dical	d			_						
1/89	tificat ng ph	a l	IF FEMALE:	N/R								
S X	th cer ttendi or use	Physician/M	23b. Was decedent pregnant 23c. If yes, out in the past 12 months?	come of pregnancy Birth 2 🗌 Fetal death	3 🗆	Ectopic pregnancy				230	d. Date of del	livery
Š Roš	e dea the a hed fo	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Preg 9 ☐ Unknown 9 ☐ Unkr	nant at time of death	5 🗌	Other (specify)	-				Month	Day Year
л О	nat thread by detac		Part II. Other significant conditions contributing to d	eath but not resulting in	n the un	derlying cause give	n in Part I.		23e Did tok	Dacco URA	contribute to	the cause of death?
S,	irres ti signe Id be	d by				, ,						robably 4 Unknown
0	v requ	lete						_ }	24a. Was ar			topsy findings available
Vital Records,	ne lav te has age 2	Completed						-	autops	ned2	prior to death?	completion of cause of
<u>a</u>	an; I		25. Was case referred to medical examiner?			26. Plac	e of Death (	Check only	1 Yes	2 X No	1 \sum Yes	2 🗆 No
<b>X</b>	nysici nis ce I direc	2	Hospital:	Inpatient 2 - ER/Out	tpatient	Others				ence 6 🗆	Other (Speci	ifu)
VISION OF	ing P		27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Mont		ime of njury	28c. Injury a work?			Describe ho			197
101	death tor, A the fi	Certificate:	2 Accident Investigation			M 1 □ Ye	es 2 🗆 No					
2 2	after Direc	Sel	4 Homicide determined 28e. Place	of Injury - At home, far ng, etc. <i>(Specify)</i>	m, stree	t, factory, office		28f.	ocation (Str	eet and N , State)	umber or Rur	al Route Number,
ָבָּ בַּ	Spiral nours neral	<u>8</u>	29a. Certifier  Check  Check  Medical Examinary On the book	est of my knowledge d	leath oc	cured at the time of	late and place	no and du	40.460			
3	To the rospital of Autonaung Prysidan; The law requires that the death certificate within 24 hours affer death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examiner: On the basionly one) 3 Certifying Nurse Practioner:									
5	vithi To th		29b. Signature and title of certifier		5-, -0	29c. License n		_ proces, all			igned (Month	
	_ ,		P Ju & John	-		D21	1944	1		Nove	mber 3	30, 2010
,	10x1		30. Name and address of person who completed cause				1		0.1 = 1			
	V-		James Grissom M.D., 147				deric	k, MD	2170	J2 —		
	State Registra		DEC 0 3 2010 Acres 32. Re	gistrar Signatura								

			For State	State of M	larylar					lental Hy	/gien	ie	
			Registrar  1. Decedent's Name (First, Middle	, Last)	-	Cer	tificate of l	Deati	<i>n</i>	2. Date of De	Reg. N	No. 201	0.37019
	Physicia Medi		JoAnn	McFee	2					Month	27	2010 2010	3. Time of Beath = 0005 A M
	Examir	ner	4a. Facility Name (if not institution	3			4b. City, Town, o				4	c. County of Dea	
	Funeral	P	Northwest Hosp  5. Social Security Number			ast birthday)	Randall If Under 1 Year		<b>∀N</b> der 24 Hrs.	O Date of Bi	-41-	Baltim	
	Director		220-36-4188	1 □ M 2 🂢 F	71	Yrs.	Months Days	Hour		8. Date of Bit 8-3-19	ay Year,	) 9. Bi	rthplace (State or Foreign ountry) MD
	at at	5	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
	Maryla 28a-f s otified	rect	MD Anne	Arundel		Glen Bu	ırnie						1 Yes 2 No
	th the	a D	10e. Street and Number				10f. Zip Code				10g. (	Citizen of What C	ountry?
	ath wi	Funeral Director	304 Highland D	rive, T3	Ever in 11.9	S 112 M	21061 /as Decedent of H	lioponio	Origina (Spec	aife i Ven en Ne		USA	
036	I 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene.  27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at	ed by F	1 ☐ Never Married 2 ☐ Marr 3 🎇 Widowed 4 ☐ Divorced	Armed Forces?		If	Yes, specify Cuba	an, Mexic	can, Puerto F	Rican, etc.)		14. Race - Ame Black, Whit Specify:	te, etc.
5-0	2 hour "natu	plete	15. Deceder	t's Education st grade completed)		16a. Deced	ent's Usual Occup	ation			16b.	Kind of Business	nite
121	thin 73 ane. than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. DC	ind of work done o NOT use retired) Libraria		ost of workir	ng			
Q 2	led wi Hygie other ent, tl	Be	17. Father's Name (First, Middle, L.	as <i>t</i> )			LIDIALIA		other's Name	(First, Middle,	Maida	Libra	ry
ylan	id be fi Menta arked atic ev	은	Ernest Tay	lor				10.1910	Edit	_	(unl	,	
Mar	shoul h and l 7 is m traums		19a. Informant's Name/Relationsh	ip (Type, Print)			Address (Street a						
<u>آ</u>	and a Healti		Marc McFee/son 20a. Method of Disposition		20h P	304 H	ighland	Dr.					
m o	Page 1. ment of I ant: If it		1 Burial 2 Cremation 4 Donation 5 Other (S)	3 Removal from State	C	emetery, crem	atory or other place ns Cemete	e) Prv	!	ate 2010		Location - City or ${\sf ownsvil}1$	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be for permit. Page 1 and 2 should be for permit if item 27 is marked any injury or other traumatic enone.		21. Signatur of Funeral Service	nsee	01364								ral Home
	and		23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that caused	the danth	n. Do not enter	the mode of dying	g, such a	as cardiac or	respiratory an	rest,	MD 2106	Approximate
	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	C ,	Spice	- 1	Kemia						Interval Between Ons, it and D-all
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289	ertifica ding p se as t	/Me	IF FEMALE:	23c. If yes, outcome of	of progner	2014							
. Box	To the troughtal or Attending Priysician: The law fequires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 🔲 No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	у		<u>.</u>		23d. Date of del Month	livery Day Year
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cords,	equires een sig ould b	ted			-			_		1 🗆 \	Yes 2	□ No 3 □ Pr	robably 🔀 Unknown
Heco	The law rate has b	Completed								24a. Was a autop perfor	SV	prior to o	topsy findings available completion of cause of
VITA	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:					eath (Check o		2 60 11		0
O 1	y Phys er this eral die	은 등	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie	y 2	R/Outpatient 28b. Time of	3 DOA Other	4 ⊔ 1		ne 5 Resid		Other Speci	ity) finet year
uo	ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investiga	tion	Year)	injury	work?	Yes 2[		od. Describe no	ow mjur	y occurred	ι
DIVISION	ral or Arra	Il Certificate:	3 ☐ Suicide 6 ☐ Could not determine		y - At hon (Specify)	ne, farm, stree	t, factory, office		28	Bf. Location (Si City or Town			al Route Number,
1	ne nospii in 24 houi he Funera	Medical	Chieck 2   Medical Ex	Physician: To the best of raminer: On the basis of ex lurse Practioner: To the b	amination .	and/or investio	ation in my opinior	a death	occurred at th	an time data ar	ad mlaca	and along the time of	
	with To t		29b. Signature and title of certifier	inst		,	29c. License		5			te signed Month	
	1	ļ	30. Name and ordress of person will have the work of the control o	no completed cause of de	ath (Item 2	23a) (Type Prir	TVR S	sut.	e De	3 Ba	ltr	noxe 1	10 21729
	State Registra	-	DEC 0 3 2010	32. Registrar	's Signatu	ire /				(-		<del>-</del> 7 (	

			For State	State of Maryla				nd Mental Hy	giene	
			Registrar		Cer	tificate of	Death		Reg. No.	0.0000
	Physicia	an/	Decedent's Name (First, Middle, Last	,				2. Date of De Month	Day Vo	3. Time of Obath
	Medi- Examir		K. Bernice M: 4a. Facility Name (if not institution, give	street and number		45 07 7		Dec. 1	, 2010	111:20 A M
	Examili	lei	315 Newfield Rd.	on out and manuscry		4b. City, Town, o		Jeath	4c. County of I	
	Funeral	Г	5. Social Security Number 6. Sec	7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24		th 9.	Arunde1 Birthplace (State or Foreign
Ŀ	Director	ı	210-10-9146	□M 2 🛛 F	Yrs.	Months Days	Hours N	Apr. 18	y, Year) 922 M	aryland
pu	how	l >	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loc	eation				10d. Inside City Limits
faryla	3a-f s tified	Director	  Maryland   Anne Ai	undel C	len Buri	ad a				1 Yes 2 K No
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uvith	nust I	Funeral	315 Newfield Rd.			21061			United St	ates
deat	or neatur and wentar Hyglene.  The surface of the tran "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Vas Decedent of H Yes, specify Cuba	ispanic Origin? ın, Mexican. Pı	? (Specify Yes or No- uerto Rican, etc.)	11.11.000 /	merican Indian,
036 s after	al", o Exam	d by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	I	☐ Yes 2 🗓 No		, ,	Spooif.	/hite, etc.
Pour Pour	natur Jical I	Completed	15. Decedent's Ed	lucation	16a. Deced	ent's Usual Occup	ation		16b. Kind of Busine	White
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	tygier ther t nt, th	Be C			Home	emaker			Own Home	
Maryland 21215-0036 2 should be filed within 72 hours after	red of	10 B	17. Father's Name (First, Middle, Last)  Charles T. Cauffn					Name (First, Middle,	Maiden Surname)	
ould b	mark matic	ľ	19a. Informant's Name/Relationship (Ty		81		Minnie			
MS 12 sh	27 is		Robert Miles / Hu			g Address (Street a Newfield		r Rural Route Numbe. Glen Burn:	r, City or Town, State,	Zip Code) .061
ian Lang	item othe		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of		Date	20c. Location - City	
Page	ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Specify	Removal from State		atory or other place en Mem. I	. 100	c. 6,	·	ie, Maryland
baltimore,	Amportant: If ite any injury or ot once.		21. Signal re of Por eral a price Licens	е	Ķi	Name and Addres	adick I	Funeral Ho	ome, P.A.	
CY			23a. Part 1. Enter the disease, or comp	lications that caused the dea					Burnie, MD	21061 Approximate
- Phys	sician/		Immediate Cause (Final	e cause on each line.	ın	^ 1		and or respiratory are	001,	Interval Between Onset and Death
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ne law	has le 2	d L						24a. Was a autops perfor	sy prior t	autopsy findings available o completion of cause of ?
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VILC	this certificaral director, p	10 B	examiner? 1 🗆 Yes 2 🔑 No	ospital: 1	ER/Outpatient	Louis	ce of Death (C		ence_6  Other (Sp	/6 \
2 g	<u>- 0</u>		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at		w injury occurred	еспу)
tendi leath.	the fu	ifice	2 Accident Investigation 3 Suicide 6 Could not be		,,		∕es 2 □ No			
Hospital or Attending Physician: The law requires that the death certific 24 hours after death.	Direct in by	Certificate:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree /)	t, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
spital	neral d filled	ica	29a. Certifier 1 Certifying Physic	cian: To the best of my know	ledge, death oc	cured at the time	date and place	and due to the caus	no(a) and manner as	ntatad
the Ho	To the Funeral Director: Afte completed filled in by the fun	Medical	only one) 3 Certifying Nurse	er: On the basis of examination Practioner: To the best of m	n and/or investig	ation, in my opinior ath occurred at the	i, death occurre time, date and	ad at the time date on	d place and due to the	a acrea(4) and decomposited at
D W	<b>6</b> 8	,	29b. Signature and title of certifier			29c. License		- 1	9d. Date signed (Mor	nth, Day, Year)
		-	80. Name and addless of person who co	mplated source of death (I)	. 00-) = - :		3462		12/1/10	
10			Tude Moveses		_	9Kw080	00	ad Calo	Bini	mD 21061
	State legistra	~	DEC 0 3 2010	32. Registrar's Signat	ture	V	7 60	OF GEN	201116	11120101
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day MANNION 6: December 15t 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death bital, 3001S Hanovers Baltimore Baltimore City 8. Date of Birth (Month, Day, Yea 6-28-1928 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 🛛 F 82 Hours Min 220-20-1817 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 118 North Longcross Rd. 21090 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 KMarried 1 ☐Yes 2 ☐No Specify: 3 Widowed 4 Divorced Specify: Year or Dates: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home maker Home Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Thuman Mary Schilling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 North Longeross Rd., Linthieum, MD Mr Charles E Mannion/spouse 20a. Method of Disposition

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mone.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

if than "natural", or items 23a or 28a-f show

"natural", or

Director

by Funeral

Completed

Be

ပ

MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

attending physician

burial-tran ģ signed by t cate has page 2 s After this of funeral direction

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examin Physician/Medical 2 Completed Be Medical Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

25. Was case referred to medical

2 No

5 Pending investigation

6 Could not be

VRUSHER

determined

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DXANA VRUSHER, 3001 SHANOVER S

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated

32. Registrar's Signature

examiner'

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 0 3 2010

1 X Burial 2 ☐ Cremation	3 Removal from State	cemetery, cremato	ry or other place)	1		. To mily oldeto
4 □ Donation 5 □ Other (Sp		Holy Cross	Cemetery	12/4/2010	Brooklyn,	MD
21. Signatura Furreral Service I	mo1364	421		SE Glen Bur	Ruddick Fund Thie MD 2106	eral Home
23a. Part 1. Enter the disease, or shock, or heart failure. List	only one cause on each line.					Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)			Scular	e Acciden	rt	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	onsequence of):	E IN	arction	/	10 days
3 220.	Due to (or as a c	onsequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 moaths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of  1  Live birth 2[ 4  Pregnant at tir 9  Unknown	☐Fetal death 3 ☐ Ect	opic pregnancy ner (specify)		23d. Date of de Month	elivery Day Year

23e. Did tobacco use contribute to the cause of death?

24a Was an autopsy 1 □Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

St, Baltimore, MB 21225

2 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

2 No

2010

DHMH 17 Rev 1/2001

Registrar

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

RES-001

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			State of Maryland / Dep		lental Hygie	ne N2010 37822	)
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death		No. UIU 01022	_
	Physicia	an/	Mabel Elizabeth Noble		<ol><li>Date of Death Month</li></ol>	Day Year 3. Time of Death	
100	Medi		4a. Facility Name (if not institution, give street and number)	T 41 - 01 - 7	December		_
3	Examir	ier	408 Greenhill Avenue	4b. City, Town, or Location of Death	İ	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Laurel If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince George's  9. Birthplace (State or Foreign	_
	Director		090-18-0350 1□M2☑F 88 Yrs.	Months Days Hours Min.	(Month, Day, Ye. Apr. 17,	ar) 1922 New York	
	_ %		Usual Residence of Decedent		1101. 177	1922 NCW 101K	
	yland f sho	햟	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits	
	Mar 28a notifi	įį	MD Prince George's Laurel			1XX Yes 2 □ No	)
	3a or	<u>=</u>	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?	
	ms 2 musi	Funeral Director	408 Greenhill Avenue	20707		USA	
	r dea	드	Affiled Folces:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
99	al", c	d by		1 ☐ Yes 2 ☐XNo Specify:		Specify: White	
ŏ	hours ratur ical I	Completed	15. Decedent's Education 16a, Dece	dent's Usual Occupation	101		_
215	an "r Med	盲	(Specify only highest grade completed) (Give	kind of work done during most of workir O NOT use retired)	ng loi	o. Kind of Business Industry	
21	within giene			al Secretary		Law Firm	
p	filed all Hy doth doth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maio		Т
yla	ld be Ment arke	욘	Reginald Cooper Hall	Grace 7	Chompson		
lar	shou and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural	Route Number, City	y or Town, State, Zip Code)	
<i>₹</i>	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Deborah L. Gyaki/Daughter 408	Greenhill Avenue,	Laurel,	MD 20707	
Baltimore, Maryland 21215-0036	t of H t of H ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ XCremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, creation state	osition (Name of D matory or other place)	ate 200	c. Location - City or Town, State	
<u>ä</u> .	permit. Page 1 Department of Important: If it any injury or o once.			ndel Crem. 12/3/	2010 0	denton, MD	
3ali	ermit epari npor ny in		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Don	aldson Fi	uneral Home, P.A.	٦
	0.07 = 40		MUILUS / MUILUS   3	<u> 13 Talbott Avenue,</u>	Laurel	, MD 20707	- 2
			23a. Part 7. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between	
F	hysician/	8	Immediate Cause (Final disease or condition Congestive Hea	rt Failure		Onset and Death	
تحريب	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		<u>~</u>	Sequentially list conditions, b. Hypertensive C	ardiomyopathy			
	sit sit	min	If any leading to in mediate cause. Enter Underlying				
de	ecute and Ftran	Examiner	Cause (Disease or linjury that initiated events c				_
	ate be executed ohysician and the burial-transit	dical					
200	death certificate be executed ne attending physician and ed for use as the burial-transi	edi	d				-
687	ath certifica attending p i for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Date of delivery	
Вох	eath e	icia	in the past 12 months?  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 1 ☐ Yes 2 17 No.  4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year	1
Θ.	requires that the de been signed by the should be detached	hys	g ☐ Unknown				
P.O.	that ned b	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?	٦
3	n sig	g			1 🗆 Yes	2 X No 3 ☐ Probably 4 ☐ Unknown	
Ö	w req	plet			24a. Was an	24b. Were autopsy findings available	$\dashv$
Division of Vital Records,	isidan: The law requires that the certificate has been signed by the lirector, page 2 should be detach.	Completed			autopsy performed	prior to completion of cause of death?	
<u></u>	an: I		25. Was case referred to medical	26. Place of Death (Check of	1 Yes 2 X	No 1 ☐ Yes 2X No	$\dashv$
	ysrci is cer direc	일	examiner? 1 ☐ Yes 2 【▼ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other		6 ☐ Other (Specify)	-1
ō	ng Prin	ë	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at 28	Bd. Describe how in		٦
ou	endir sath. or: Af he ful	<u> </u>	2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No			
ISI/	ter de	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office		and Number or Rural Route Number,	7
ă	ral Di			1	City or Town, Sta	•	1
1	or the Topstrae or Automating Prysician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death of Medical Examiner: On the basis of examination and/or investigation.	idation. In my opinion, death occurred at the	ne time date and nla	ice and due to the cause(s) and manner stated	٦
4	thin 2	— r	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, of 29b. Signature and title of certifier	eath occurred at the time, date and place,	and due to the caus	e(s) and manner as stated.	
,	× ≥ ⊬ 8		I level S. Wyatt, mo	29c. License number		Date signed (Month, Day, Year)	
	,			D62063	D	ecember 1, 2010	┙
	5		<ol> <li>Name and address of person who completed cause of death (Item 23a) (Type, P Jenel Wyatt, MD, 14207 Park Cente:</li> </ol>		T 7	WD 00505	
	State			Drive, Suite 102	, Laurel,	MD 20707	4
	Registra	r	31. Date filed (Month 3 2000)  Server 32. Registry's Signature 32. Registry's Signature 4.				
							_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month November 30, 5:25 AM Emoline Theresa Phillips 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2300 Dulaney Valley Rd. Lutherville-Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 KF Jul 09, 90 Director Yrs 1920 West Virginia 232-22-9825 Usual Residence of Decedent 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s 1 Yes 2 No MD Baltimore Lutherville Timonium ŏ 10e. Street and Numbe 10f. Zip Code ms 23a or must be a 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 United States ural", or items? death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", other traumatic event, the Medical Exal 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hetzlers Sales Assocation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Antonio Crusifixo Pizzafortato Poles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Robert A. Phillips /Son 8500 Harris Ave. Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 12.01.10 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility MU1443 Cremation and Funeral Alternatives \$717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician, MENTI MONT Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months? Month Day Year detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy performed? Yes 2 No 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation М 24 hours after deatl Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one 29b. Signature and title of certific မ License number 29th Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

9

Registrar

State

2010

NOVEMBER

PHILLIPS

EMOLINE

2300 DULANEY VALLEY ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

ERNESTINE WRIGHT

31. Date filed (Month, Day, Year)

**DEC 0 3 2010** 

DM 2010

TIMONIUM, MD 21093

Description   Comparison   Co				For State	State of Ma	aryland /	Department of		d Mental Hy	giene			
Formula Service Control of Control Con				Registrar  1. Decedent's Name (First, Middle, I	Middle, Last) 2. Date of Death								
Part   Part	Н	Medi	cal	DENNIS		RAR	0		Novemi	Day Year	1 10-1		
Second Second Prince   The Control Prince   The C		Exami	ner			L	4b. City, Tow			4c. County of De	eath		
Construction   Cons		Funeral	Г	Social Security Number     6	. Sex 7. Age	(In yrs. last b		ear If Under 24 F	rs. 8. Date of Birt	th 9. E	Birthplace (State or Foreign		
State   Stat					1 <b>X</b> JM 2 L F	80	Yrs. Months Da	ys Hours M	Jun 2	5 Year) 1930 Ma	Tyland		
The property of the property		land show dat	ţō	10a. State 10b. County		10c. City, Tox		<del></del>			10d. Inside City Limits		
The property of the property		e Mary r 28a-1 notifie	Jirec		timore						1 ☐ Yes 2 No		
The property of the property		th with the ns 23a or must be	neral	4	enue		10f. Zîp Cod						
To put the part of	9003	urs after deai tural", or iter al Examiner	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 1  If Yes, Give  Year or Dates.	ver in U.S. No <b>Kore</b>	a If Yes, specify C	uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, Wh	ite, etc.		
23. Part 1. Enter the disease, or complications that caused the death. Direct enter the mode of dying, such as cardiac or respiratory arrest, immediate cause of individual for course on each line.  1	15-	72 ho in "na Medic	mple	(Specify only highest	grade completed)		(Give kind of work do	ne during most of w	vorking	16b. Kind of Busines	s Industry		
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23. Part 1. Enter the disease, or complications that caused the death. Direct enter the mode of dying, such as cardiac or respiratory arrest, immediate cause of individual for course on each line.  1		d 2 should safth and P									Zip Code)		
23. Part 1. Enter the disease, or complications that caused the death. Direct enter the mode of dying, such as cardiac or respiratory arrest, immediate cause of individual for course on each line.  1	more	Page 1 an nent of He int: If iten iry or othe		1 Burial 2 ☐ Cremation 3	☐ Removal from State	20b. Place	of Disposition (Name of	1	Date	20c. Location - City of			
Approximate from the cause of the death. In not enter the mode of dying, such as cardiac or respiratory arrest, increased late the second or respiratory arrest, increased late the second or respiratory arrest, increased late the second or respiratory arrest, increased late the second or or respiratory arrest, increased late the second or or respiratory arrest, increased late the second or or or respiratory arrest, increased late the second or or or respiratory arrest, increased late the second or or or respiratory arrest, increased late the second or or or or or or or or or or or or or	Balti	permit. I Departm Importa any inju		1 611		Dlar	22. Name and Add	dress of Facility	Imbrose Fi	uneral Nome	e, Inc.		
Sequentially list conditions of a consequence of):    Present   Pr	-			Immediate Cause (Final disease or condition	one cause on each line.	is	not enter the mode of d				Approximate Interval Between		
THE INTERIOR OPENING  THE INTERIOR OPENING			ər		b. Pneul	moni	a				1-2 weeks		
Due to for as a consequence of):    Week		cuted nd ransit	amin	if any, leading to immediate eause. Enter Underlying Cause (Disease or linjury that initiated events	4			Injur	1		1-2 weeks		
Note: State:    FFEMALE:   FFEMAL	09.	ate be exec	dical E	resulting in death) Last							I week		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Ol South Hanover Street, Baltimore, MP 2/225  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	. Box 687	ne death certific. / the attending p		23b. Was decedent pregnant in the past 12 months?	1 ☐ Live Birth 2 4 ☐ Pregnant at	Fetal deat							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Ol South Hanover Street, Baltimore, MP 2/225  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ls, P.O	ires that the signed by the detail		Part II. Other significant conditions Parkinson	contributing to death but	t not resulting	in the underlying cause	given in Part I.					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Ol South Hanover Street, Baltimore, MP 2/225  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ecord	has beer te 2 shou	mplete					1 - 10	24a. Was a	n 24b. Were at	utopsy findings available		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Ol South Hanover Street, Baltimore, MP 2/225  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	E Re	in: The ificate or, pag			rsion;	Chro			- 4		s 2 No		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Ol South Hanover Street, Baltimore, MP 2/225  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	on of	nding Ph ath. r: After th e funeral		1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28b.	Time of 28c. Inj	ury at ork?			sny)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Ol South Hanover Street, Baltimore, MP 2/225  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Division	al or Atte s after de Il Directo d in by th		3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury	/ - At home, fa (Specify)	arm, street, factory, office	е	28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Ol South Hanover Street, Baltimore, MP 2/225  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		ne Hospit n 24 hour ne Funera	Medica	Check 2 - Medical Exar	niner: On the basis of exa	mination and/o	or investigation in my oni	nion death accurred	d at the time date on	d place and due to the			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAG  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAGA  30. I and address of person who completed cause of death (Item 23a) (Type, Print) JAVZANDULAM NATSAGA  30. I and address of person who completed cause of death (Item 25a) (Type, Print) JAVZANDULAM NATSAGA  31. Date filed (Month, Day, Year) 32 Registrar's Signature		vithi To th			P		29c. Licer	ise number	2	9d. Date signed (Mont	h, Day, Year)		
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		Thy)					Type, Print)	VZAND	OLAM	NATSA	+G		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 3:07 A M LOUISE Kedmono November 30 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital -6 Baltimore Baltimore 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under **Funeral** Months Days Min Hours 1 □ M 2 🖫 F 214-22-2577 Director Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f shov ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Modical Exeminar must be notified at 1 ☐ Yes 2 ₩ No **Funeral Director** timore MD 10g. Citizen of What Country? 10e. Street and Number 6810 21201 arsons 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after I Hygiene. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No ş Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) tructiona 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi ပ္ Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is any injury or an MD 21076 Garre Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or others) Date 3 Removal from State 1 D Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) -6 2010 22. Name and Address of Facility Va ushn Greene Funeral Services 21. Signature of Funeral Service Licensee Randallstown, MD 01133 an 23a. Part 1. Enter rije disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or his tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intracerebral 1 month disease or condition resulting in death) Hemorrhage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy rmed2 2 No After this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by determined 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 059062 November

Registrar DHMH 17 Rev 1/2001

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State

Chad J.

DEC 0 3 2010

Date filed (Month, Day,

W Belvedere

Baltimore

21215

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hansen

M.A.

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 Physician/ 2330 VOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIT BALTIMORE OF BALTIMORE 7. Age (In yrs. last birthday)
57 Yrs. If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Country) Funeral 1 M 2 🗆 F Hours Min Month Dy Director or 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? items 23a Funeral 1207 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Exam<u>in</u> Completed by 1 Never Married 2 ☐ Married 2 **X**No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Give find of work done during most of working life #O NOT use retired) Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) archouseman Be 17. Father's Name (First, Middle, Las ပ uren ce Koane 6712 20b. Place of Disposit Burial 2 Cremation 3 Removal from State **I** cemeterv. c. 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPSIS Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Directo for cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital Other: 욛 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred s after death. Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No. Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. RES - 000 30,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI BALTIMORE HOSPITAL State Registrar

RUNGLD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Unk M Medical 4b. City, Town, or Location of Death Name (if not institution, give 4c. County of Death Examiner BaltiMore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of girth Birthplace (State or Foreign Country) (Month **Funeral** 1 M 2 KF 193 Director 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 21202 Funeral mit. Page 1 and 2 should be filed within 72 hours after death a partment of Health and Mental Hygiene. octant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner my Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 🌠 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) Elementary Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, ပ 19a. Informant's Name/Relationship (Type, Print) . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Town, permit. Page 1 Department of I Important: If its 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) olon near Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death been signed by the sahould be detached f g Unknown g Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe Yes 2 No 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 XiNo 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) re and title of certifie 29d. Date signed (Month, Day, Year) 29b. Signat 2010 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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		-	1 _ State	partment of Health and N ertificate of Death		0010	07000
	Physicia	n/	Decedent's Name (First, Middle, Last)	similate of Death	2. Date of Death Month	Day Year	3. Time of Death
	Medic Examin	al	DOROTHY GEE REDDICK  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Nanmper	Day Year 28 2010 4c. County of Deat	
1		<b>J</b> .	Union Memorial Hospital  5. Social Security Number   6. Sex   7. Age (In vrs. last birthda	Baltimore	L o D ) (D:#	None	
	Funeral Director		461–30–1373 1 □ M 2XX F 87 Yrs	Months Days Hours Min.	8. Date of Birth 12/13/1922	ear) Texa	hplace (State or Foreign Intry)
	and show 1 at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d, Inside City Limits
	e Maryl r 28a-f notifie	Direct	Maryland None Baltimo	10f. Zip Code	1.0		1 XXYes 2 □ No
	with the s 23a o	Funeral Director	722 East Belvedere Avenue	21212	109	g. Citizen of What Co USA	untry?
9800	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		11. Marital Status  1  Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces 1  1 Yes, Give  Year or Dates.	Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto     □ Yes 2 XX No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B	
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "nat , the Medica	Completed by	(Specify only highest grade completed) (Gi Elementary/Seconday (0-12) College (1-4 or 5+)	cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired)	ing 16	Baltimore	
yland	2 should be filed Ith and Mental Hy 27 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last)  Major Gee	į.	e (First, Middle, Maid e Wright	den Surname)	
, Mar	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once,		19a. Informant's Name/Relationship (Type, Print) L Taylor Avery Son 19b. M. 7021	ailing Address (Street and Number or Rura Highland Spring Lane, H	al Route Number, Cit lighland , C	ty or Town, State, Zip alifornia 92	2346
imore	Page 1 ar ment of Ha ant: If iter ury or oth		1 D Burial 2 XX remation 3 D Removal from State cemetery, o	position (Name of rematory or other place)  Crematory 12/03/		c. Location - City or <b>ltimore, Ma</b> r	
Balt	permit. Departr Imports any injt		21/Signature of Funeral Schick Lightisee  AMMUS CHARIS	22. Name and Address of Facility Mitc 6500 York Road Baltin			Home Inc
	nysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)  a. Due to (or is a consequence of):	, c			Laucok
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undergong Cause (Disease or impury that is listed awards.)	19.19.192			2 months
) 09	oe e iciar buria	dical Exa	that initiated events resulting in death) Last  C. Due to (or as a consequence of):	an stronger			24 11/05/10
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	B		23d. Date of del	iv <b>ery</b> Day Year
s, P.O.	uires that th signed by Id be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the			cco use contribute to	the cause of death?
Division of Vital Records,	The law req tte has bee page 2 shou	Completed		1	24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Ita	certifica rector, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: Inpatient 2 FR/Outnatient	26. Place of Death (Check	k only one)		
on of V	nding Physath. : After this e funeral di	icate: To	1  Yes 2  No Inpatient 2  ER/Outpa  27. Manner of Death 1  Natural 5  Pending 2  Accident Investigation  28a. Date of injury (Month, Day, Year)  injure	of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how i	e 6 Other (Specinjury occurred	<u>ffy)</u>
Division	tal or Atters after deal Director	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	the Hospit in 24 hour the Funera ipleted fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or involved 3 Certifying Nurse Practioner: To the best of my knowledge	restigation, in my opinion, death occurred a e, death occurred at the time, date and place	t the time, date and pose, and due to the cau	place, and due to the duse(s) and manner as	ause(s) and manner stated. stated.
	North		29b. Signature and title of certifier  Hawan Nasur MD	29c. License number D 53617	29d	Date signed (Month	, Day, Year) - 29,2010
	8		29b. Signature and title of certifier  Hawan Masser M  30. Name and address of person who completed cause of death (Item 23a) (Type Hassan Masser Union Memorial has 11. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Strauth	:, Print) 2012. Unin	uchy fail	eway. B	altimore, MD
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 32. Registrar's Sharpel				

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			_ State	tate of Maryland		tment of H		Mental Hy	2011	0 37829
			Registrar  1. Decedent's Name (First, Middle, Last)		- 0071	incate of D	Gatti	2. Date of De	Reg. No. ← U 1	3. Time of Death
	Physicia Medic		JUNE ROBERT	SON				NOVEM.	BER 27 26	
. *	Examir	er	4a. Facility Name (if not institution, give stree			4b. City, Town, or I		h	4c. County of De	
			JOHNS HOPKINS BAYVI 5. Social Security Number 6. Sex				TIMORE			
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year) C	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					July 1	4, 1936   Mi	chigan
	yland -f sho ed at	ctor	10a. State 10b. County FLA Bay	10c. City,	Town or Loca					10d. Inside City Limits
	r 28a notifi	Director	10e. Street and Number		Pana	ama City				1 X Yes 2 No
	vith th	ral	4304 Legend P	1		10f. Zip Code 3241	1		10g. Citizen of What 0	
	er mu	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. Wa	s Decedent of His	panic Origin? (S	pecify Yes or No-	U.S.	
တ္တ	fter de , or if	by	1 ☐ Never Married 2 ☐ Married	Armed Forces? □ Yes 2 🌠 No f Yes, Give	If Y	es, specify Cuban	, Mexican, Puert	o Rican, etc.)	Black, Wh	ite, etc.
ğ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	3 K Widowed 4 🗆 Divorced	ear or Dates.		Yes 2 X No			Specify: W	hite
5	72 hc in "na Medio	nple	15. Decedent's Educati (Specify only highest grade co	mpleted)	(Give kin	nt's Usual Occupat d of work done du NOT use retired)	tion <i>iring most of wol</i>	rking	16b. Kind of Busines	
212	within giene. er tha	ပိ	Elementary/Seconday (0-12) (	College (1-4 or 5+)		reacher			Public	School
b	should be filed within 72 n and Mental Hygiene. 7 is marked other than " raumatic event, the Mec	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
yla	should be file n and Mental I 7 is marked o raumatic eve	은	Giovanni Baggio:				Maria	Digher	a	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	1	19a. Informant's Name/Relationship (Type, P	19					r, City or Town, State, Z	
	and 2 s Health tem 27	1	Robert Roberts  20a. Method of Disposition		ce of Disposit		T, Apt	Date IB, I	20c. Location - City of	NY 10022
D E	Page 1 ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cem		ory or other place,	; 500	cember	New Bei	
Baltimore,	permit. Page 1 Department of Important: If i any injury or c	1	21. Signature of Funeral Service Licensee	PINIS	22. N Eva	lame and Address	of Facility	2010   napel &		
	45 2 0 0	8 8	2 a. P.rt I. Enter/the disease, or complication	ons that caused the death.	B80	0 Harf	ord Rd	Parky	ille, MD	on Services 21234
	hysician/	0 15	s rock, or heart failure. List only one cauli mediate Cause (Final	ise on each line.				or respiratory an	631,	Approximate Interval Between Onset and Death
	Medical		resulting in death)	RESPIRAT  Due to (or as a consequent	oce of):	MILUKE	5			Onset and Death 5 WEEKS
	Examiner	L	Sequentially list conditions, b. —	PLEURAL	EFFA	NIONS				2 MONTHS
-	d sit	Examiner	if any, leading to immediate	Due to (or as a consequen						
	be executed sician and burial-transi	Exar	Cause (Disease or iinjury that initiated events c. — resulting in death) Last	SCLERODE  Due to (or as a consequent	ice of):	<del></del>				30 YEARS
00	be e sicial buri	dical	d		,					
3/6	ificate ig phy as the	Med	IF FEMALE:							
χ Χ	death certificate ne attending physed for use as the	ian/I	23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy	eath 3 🗌 E	ctopic pregnancy			23d. Date of de	elivery
Rox	r requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	1 Yes 2 No 4	☐ Pregnant at time of dea☐ Unknown	ith 5 🗆 C	other (specify)			Month	Day Year
7. Ö	hat th ed by detac	y Ph	Part II. Other significant conditions contribu	ting to death but not resulti	ing in the und	erlying cause give	n in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
S,	uires t n sign ald be	ed by						1 🗆 1	/es 2 <b>1</b> No 3 □ F	Probably 4 🗆 Unknown
Š	w req	plet						24a. Was a	an 24b. Were a	utopsy findings available
Vital Records,	The la ate ha	Completed		1-1				autop perfor 1 V Yes	med? death?	completion of cause of
四	cian: ertific ector,	Be	25. Was case referred to medical examiner?	al.			e of Death (Chec			2 2 110
<u> </u>	Physi this c	<u>٩</u>	1 Li Yes 2 LZ No	1 Inpatient 2 ER	Outpatient  b. Time of				ence 6 Other_(Spec	cify)
DIVISION OF	tth. : After e funer	Certificate;	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury a work? M 1 🗆 Ye	it es 2 □ No	28d. Describe h	ow injury occurred	
<u>  2 </u>	Atter er des ector by the	erti.	3 Suicide 6 Could not be	e. Place of Injury - At home					treet and Number or Ru	ural Route Number,
<u>}</u>	ital or irs aftural Dir			building, etc. (Specify)				City or Town		
;	To the laspital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: 0 Gertifying Nurse Practical Certifying Physician: 2 Certifying Physician:	1 the basis of examination an	id/or investiga	tion, in my opinion.	death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated
	vithi To the		29b. Signature and title of certifier	an .		29c. License n			29d. Date signed (Mont	
			Midral V. Bal	El, HD		RES-	-000	/	SOVETHBER X	27,2010
			30. Name and address of person who comple  ANOREAS S. BARTH	4.0. 4940.	EASTER	N AVEN	UE BA	LTIMORE	F, 40 210	224
	Stat	_	DEC 0 3 2010	32. Registra s Signature	Med				/	
	Registra		DEC O O ZOTO CENO	~ / / / / / / · / / · · / / · · · / / · · · / · · · · / · · · · / · · · · · / · · · · · · / ·						

amend 26, per phy, g924 2-28-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 10a-f, per fh, g924 2-28-12 sm
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar				,	ificate of L	Death		Reg. No.	010	27030		
	Physicia	in/	1. Decedent's Name Ear1	(First, Middle, L	ast) Henry		Rix			2. Date of De Month Decembe		2010 <sup>ar</sup>	3. Time of Death 12:30P M		
	Medio Examin			ot institution, gi	ve street and number)			4b. City, Town, or	Location of Death			County of Death	12:30P W		
				orsey R				Hanover				Anne Arundel			
	Funeral Director		5. Social Security Nur  484-18-8( Usual Residence of E	)34	Sex 7. Age 1 ★ 2 □ F	(In yrs. last bir 89		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug • I	th , Year 1921	9. Birth Cour	place (State or Foreign otry) IA		
puelviel	Ba-f show	Funeral Director		10b. County Wetze	1	10c. City, Tow Lit	ttlet						10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
d d d	a or 2 be no	al Di	10e. Street and Num	perP.O. B	ox 229			10f. Zip Code	26581			en of What Coul	ntry?		
ath wit	ms 2:	uner	1151 Dore	ey Road	12. Was Decedent E	ver in U.S.	13 W	-21076	spanic Origin? (Sp.	ecify Yes or No-	U.S	. A .	ean Indian		
Baltimore, Maryland 21215-0036 permit: Page 1 and 2 should be filed within 72 hours after de	of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Marrie		Armed Forces?			es, specify Cuba Yes 2 Ⅺ No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	Rican, etc.)		Black, White,			
15-0	"natu ledical	Completed	(Spec	15. Decedent's fy only highest of	Education grade completed)	16a	(Give kir	nt's Usual Occupad of work done	ation luring most of work	ing	16b. Kind	d of Business In	dustry		
Z1Z	iene. er than the M		Elementary/Secon	nday (0-12)	College (1-4 or 5- 4			NOT use retired) rical Eg	ineer		West	tinghous	se.		
nd	tal Hyg	To Be	17. Father's Name (Fi		)				18. Mother's Nam		Maiden Su	rname)			
<b>5</b>	d Men marke matic	-	Frank Her  19a. Informant's Nan		(Tune Print)	1401	- M-98		Katherine						
Saper	alth an 27 is				ink/ Daught				oad Hanov				Jode)		
			20a. Method of Dispo		☐ Removal from State	20b. Place o	of Disposi ery, crema	ion (Name of tory or other plac			20c. Loca	ation - City or To	own, State		
	Department of Important: If any injury or once.		4 ☐ Donation		Removal from State	Atlan		Cremator	y 2010 s of Facility Sin			Burnie			
מ מ	Impo any any	12	Lines 1	1 Can	Eight MO	1594							MD 21061		
			shock, or heart	failure. List only	pplications that caused one cause on each line.			he mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between		
	rysician/ Medical		Immediate Cause (Fi disease or condition resulting in death)	nal	a. Due to (or as a	274	-0:	men	n's				Onset and Death		
Á.	xaminer			f	Due to (or as a	•	01):								
g	#	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly	ing	Due to (or as a	consequence	of):					= =			
xecute	n and al-trans	Exar	Cause (Disease or iir that initiated events resulting in death) La		c. Due to (or as a	consequence	of):								
Se be e	ig physician and as the burial-transit	Medical	d												
oo /	ding ph se as th		IF FEMALE:		23c. If yes, outcome o	f pregnancy					1.				
. <b>BOX</b>	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent p in the past 12 m 1  Yes 2 9  Unknown	onths?	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal deatl		Ectopic pregnanc Other (specify)	у		23	d. Date of delive Month	ery Day Year		
s that th	igned by be deta	by	Part II. Other signific	ant conditions	contributing to death bu	t not resulting i	in the unc	erlying cause giv	en in Part I.				e cause of death?		
require	been s	leted	6 7000	Nic	atri	<u>~</u> 1	C	bolls	700	24a. Was			pably 4X Unknown		
The law	icate has r, page 2 s	Completed	OF IM-s again reformed	to modical			<u> </u>			autop perfo 1 🗆 Yes	rmed?	prior to con death?	mpletion of cause of		
VILCII ysiciar	s certif directo	To Be	25. Was case referred examiner? 1 ☐ Yes 2 💢		Hospital:	nt 2 🗆 ER/Ou	utpatient	Otho	r: 4 \ Nursing Ho		lense 6 X	Other (Specify	Daughter's Residence		
o Ha	fter thi		27. Manner of Death  1 XNatural	5 Pending	28a. Date of injury (Month, Day,	28b. 7	Time of njury	28c. Injury work	at	28d. Describe h			RESTREME		
SION	death	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not	be 280 Place of Injur	v - At home, fa	rm, street		Yes 2 ☐ No	28f. Location (S	treet and N	lumber or Rural	Route Number		
tal or /	rs after al Dire ed in b		4 U Homicide	determined	building, etc.					City or Tow					
Hospi	24 hou Funer leted fill	Medical	(Check 2	Medical Exan	ysician: To the best of m niner: On the basis of exa rse Practioner: To the b	amination and/o	r investiga	ation, in my opinio	n, death occurred at	the time, date a	nd place, ar	nd due to the cau	use(s) and manner stated.		
To the	within To the compl		29b. Signature and tit		ise Fractioner. To the D	est of filly knowl	euge, dea	29c. License	number		29d. Date s	signed (Month, L	Day, Year)		
	50		100	> M	-00	MD			3726			02,2			
	30		30. Name and address	of person who	completed cause of dea	ath (Item 23a) (	Type, Prin	アルシ	スクのもの	en l	z~~	wo kur	an ma		
	Stat Registra	•	31. Date filed (Month, DEC 03 2		32. Registrar	s Signature	1	0							

			Please	Type or Pri							•	•	le.		
			For State	State of M	arylan		artmen ertificate			nd Menta			279		
Ė			Registrar  1. Decedent's Name (First, Middle, La	ast)			in timodite	01 L	Catri	2. Date	Reg. e of Death	No. 20	07	3. Time of	Death
	Physicia Medio		MAURICE	ROSENBL	MOO					Dece	in ber	Day 20	ear	1830	
5	Examin		4a. Facility Name (if not institution, giv		-				Location of I			4c. County of	Death		
^	Funeral			Sex 7. Aq	e (In yrs. la	ast birthday)	If Under	1 Year	ve Cit	rs. 8. Date	of Birth	N/A	. Birthpla	ace (State c	or Foreign
	Director		370-24-3332	1 X M 2 D F	88	Yrs.	Months	Days	Hours	Min. 047	21719	22	Country		
	ind show at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	ocation						10	d. Inside Ci	ity Limits
	Maryla 28a-f s ptified	Director	MD N/A		В.	ALTIMO	ORE							1 🔀 Yes	s 2 □ No
	filed within 72 hours after death with the Maryland the Hygiene.  4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	al Di	10e. Street and Number				10f. Zip				10g	. Citizen of Wha	t Countr	y?	
	ath wit	Funeral	6317 PARK HEIGH					2121		n? (Specify Yes	or No-	USA 14. Race -	Amorios	Indian	
9	or ite	by F	1 ☐ Never Married 2 🔀 Married	Armed Forces?			If Yes, speci	ify Cuba	n, Mexican, F	Puerto Rican, e	tc.)		White, etc		
8	rurs af tural", al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			1  Yes 2				Specify:			ITE	
7	72 ho in "na Medica	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give	edent's Usual e kind of work DO NOT use	k done d	ation luring most o	f working	16	b. Kind of Busin	ess indu	stry	
212	within giene. er tha i, the l		Elementary/Seconday (0-12)	College (1-4 or 5 4	)+)		NER					REAL	ESTA	TE	
nd	rould be filed with nd Mental Hygier s marked other t matic event, th	To Be	17. Father's Name (First, Middle, Last)		DOC.	ENDI O	<b>7</b> M			s Name <i>(First, I</i>	Aiddle, Maid	len Surname)		T TECC	מתדווים
Ž	should b and Mer is mark raumatic		HYMAN  19a. Informant's Name/Relationship (	Type, Print)	RUS	ENBLOC		/Stroot a		ECCA	Number Cit	y or Town, State		LIFSC	,п112
Š	d 2 sh alth ar n 27 is ertrau		RUTH ROSENBLOOM			1						BALTIM			1215
ore,	e 1 an : of He If item or othe		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 [	Removal from State			osition (Nam ematory or ot			Date		c. Location - Cit	y or Tow	n, State	
Baltimore, Maryland 21215-0036	oernit. Page 1 and 2 should be Department of Health and Ment Important, If item 27 is marke any injury or other traumatic o		4 Donation 5 Other (Spec	ify)	BN.		RAEL C			2/02/20		OXON HI			
Ba	21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BR 8900 REISTERSTOWN ROAD, PIKESVILL													208	
П			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death							<u> </u>	A	Approximat	te
4	hysician/	n i	Immediate Cause (Final disease or condition	a. Hyperca we		piratory	Failure	. ,						Onset and I	Death
	Medical Examiner		resulting in death)											3. 4.	i
	100	ner	Sequentially list conditions, if any, leading to immediate	b. Pulmos	a consequ	elica vij.	ω,						+	3 wee 3wee	Kg
	executed ian and irial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C			t Failure						$\perp$	3wee	ks
	e 'E . E	<u></u>	resulting in death) Last	Due to (ór as a	a consequ	ience of):									
09/89	to the hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica		d											
9 ×	r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 \sum Live Birth			☐ Ectopic p	regnanc	v			23d. Date o	,		
Rox	e deat the at hed fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of d	leath 5 [	Other (spe	ecify)				Month	D	ay `	Year
Э.	that the		Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the	underlying c	ause giv	en in Part I.	236	. Did tobac	co use contribut	te to the	cause of d	eath?
g.	quires en sigr ruld be	ed b	orteoarthritis	, osteopo	rosis						1 🗌 Yes	2 No 3	Proba	bly 4 🗌	Unknown
Š.	law rer las ber las sho	Completed by								248	a. Was an autopsy	prio	r to comp	y findings a pletion of c	
ž T	n: The icate h r, page		25. Was case referred to medical							1.0	yes 2			No	
VITa	ysiciar s certii directo	To Be	examiner?  1  Yes 2 No	Hospital:	ent 2 🗆	ER/Outpatie	ent 3 🗆 DO	Otho	r·	(Check only on		e 6 Other (S	Snecify)		
Division of Vital Records,	ng Fn fter thi meral	ite: 1	27. Manner of Death  1 Natural 5 Pending	28a. Date of inju (Month, Day	ry [	28b. Time o injury		Bc. Injury work	at			njury occurred	poony		
loi	death. tor: Ai the fu	Certificate:	2 ☐ Accident Investigation 1 ☐ Suicide 6 ☐ Could not	he l		farm at	M	1 🗆 '	Yes 2 □ No				5 15	77.	
<u> </u>	al or A safter I Direc d in by		4  Homicide determined	28e. Place of Inju building, etc			reet, lactory,	Onice			or Town, St	and Number or ate)	' Kurai K	oute Numb	er,
	f hours uneral ed fille	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exan	ysician: To the best of niner: On the basis of e	my knowle	edge, death	occured at t	he time,	date and pla	ice, and due to	the cause(s	) and manner as	s stated.	e(s) and ma	nner stated
	the Fithin 24 the Formplet	Me		rse Practioner: To the			death occurr	red at the			e to the cau	se(s) and manne	er as state	ed.	THIS STATE OF
	- 3 ¥ ĕ		Dan Dr.	Bon.	) MR	PhD	250.		5-00	0	-	Date signed (M Peember			)
			30. Name and address of person who		eath (Item		Print)						- 1		
			David R. Benavii 31. Date filed (Month, Day, Year)	Jes, MD, Ph 32. Registra		LIFO			tospite	al of B	altimi	ore			
	Stat Registra		Day, rear)	010 32. Registra	u s signat	ure	good. I	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37832 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 01, CHARLOTTE 2010 RIVLIN 11:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Director 0370171912 Country) 106-18-9374 98 NY Usual Residence of Decedent 10a. State Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD MONTGOMERY ROCKVILLE 1 Tes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6121 MONTROSE ROAD 20852 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? ō Completed by 1 Never Married 2 Married "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RIVLIN FANNIE ABRAMOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET BERLIN/NIECE 8101 CONNECTICUT AVE, APT N-104, CHEVY CHASE, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) BNAI JACOB CEMETERY ! 12/2/2010 BALTIMORE, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. rott 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Demostra En Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) signed by the a page 2 s

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law completed filled in by the funeral director, 24 hours after death. Funeral Director: A

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 🗌 Ecto	pic pregnancy er (specify)		23d. Date of delivery  Month Day Year
Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underly	ing cause given in Part I.		to use contribute to the cause of death?
				1 🗆 Yes	2 X No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed 1 🗆 Yes 2 🔀	
25. Was case referred to medical examiner?			26. Place of Death (Che		
T les 2 parino	Hospital: 1  Inpatient 2  I	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1  Yes 2  No	28d. Describe how in	jury occurred
4 ☐ Homicide determined	building, etc. (Specify)			City or Town, Sta	
(Uneck 2 Li Medical Exami	sician: To the best of my knowle ner: On the basis of examination to Practioner: To the best of my	and/or investigation	<ul> <li>in my opinion, death occurred</li> </ul>	at the time, date and pla	ice and due to the cause(s) and manner stated
29b. Signature and title of certifier			29c License number	1 200 1	Data siana di Adamtia Bara Vand

29c. License number

Doo 64871

29d. Date signed (Month, Day, Year)

Dec 1, 2010

Rockville MD

State

Registrar

Montrose

6121

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazli

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15 A 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVEN COMMUNIT Y CIVINO CENTER Social Security Number If Under 1 Year If Under 8. Date of Birth (Menth, Day, Sex 1 M 2 □ F Birthplace (State or Foreign Country) Funeral Months Country) Director 28a-f shov 10c. City, Town or Location 10d. Inside Cify Limits with the Maryland Examiner must be notified at **Funeral Director** Baltimore 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? ò 23a Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DA NOT use retired) Elementary/Seconday (0-12) Be Tather's Name (First Middle, Last) ဂ္ Method of Disposition Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 5 Other (Specify) 21. Signs ture of Funeral Se 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, after this certificate has 8 completed filled in by the funeral director, page 2 s performed? Yes 2 X N 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5 and address of person who completed cause of death (Item 23a) (Type, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ : 30 AM Summers Medical 4a. Facility Name (if not institution, give street and number) Examiner ity, Town or Location of Death 4c. County of Death vivdale 1timore If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign 1 M 2 F Months Hours Min. Director 28a-f show 10a. State within 72 hours after death with the Maryland notified at City, Town or Location Director 10d. Inside City Limits Yes 2 No more 10e. Street and Number b 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. ife. DO NOT use retired) College (1-4 or 5+) To Be other traumatic event, Page 1 and 2 should be filed and the stand Hydrand Mental Hydrant: If item 27 is marked oth 17. Father's Name (First, Middle, Last Mother's Name (First, Middle\_Maiden Surname) 19a. Informant's Name/Relationship (Typ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) hroni 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once, 9 4 Donation 5 Other (Specify) Signature of Funeral Se vice icenses wo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dronar disease or condition Medical resulting in death) Due to (or as a consequence xaminer Sequentially list conditions, I a y lead star model cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consecuence of the attending physician and hed for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Year Day 2 🗌 No been signed by the should be detached g Unknown a 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 PM6 within 24 hours after death.

To the Funeral Director; After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an epression perform 2 No 1 Yes Be Was cose referred to social examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🖬 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of the 28a. Date of injury Time of Certificate: 28b. 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) atural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical Catheryn Stepney 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Keswick Multi- Care Lanter Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 J Days Hours Min. (Month, Day, Year) Director 219-22-4557 93 17 02 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Bal<u>timore</u> 1 Yes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1642 Fulton 21217 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. within 72 hours after 2 💢 No Yes "natural", If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3X Widowed 4 □ Divorced Completed Specify Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) ProvidenceHospital 2th grade 5vs+ Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Leonard E. Collier Amanda Flemings 19a. Informant's Name/Relationship (Type, Print)
Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 3009 Gwynns Falls Parkway, Baltimore, <u>Deborah Von Hendricks</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 12/4/2010 Arbutus, Md . Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Jomnediate Cause (Final Physician/ disease or condition resulting in death) a Vascular Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Unknown Month Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown cate has t 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate I performed? Yes 2 No death? funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Tes 2 No ျ Other: ASSIGNA After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death

Director; / Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in I 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 ho

To the Fune (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2 29c. License number Rosenthul Cantrusief

DHMH 17 Rev 7/2009

State Registrar 608 Edgevale Road

Baldimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Sig

November 30, 2010

10-08967		Please Type or Print in Black Indelible Ink.			gible.	
Richard John So	cond	Ctate of Maryland / Bopartmont of the		lygiene	2010	37836
		1- For State Certificate of De	∍ath		eg. No.	
Physici Medical Exami				2. Date of Deat Month November		3. Time of Death 1610 hrs
			ity, Town, or Location of Deat alisbury	th	4c. County of Death Wicomico	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24Hr	rs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	
Director		490-90-6529 1 X M 2 F 41 Yrs.	lonths Days Hours Mil		15,1968 Co	untry) Missour
, u		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	<del></del>			10d. Inside City Limits
nd show a	<u> </u>	Maryland Wicomico Salisbury				1 Yes 2 No
daryla 28a-f	Director	10e. Street and Number	f. Zip Code	10	0g. Citizen of What Cou	ntry?
the National states	Ē	1404 East Upland	21801		U.S.A.	
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 13. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		<ul> <li>14. Race - Amen</li> <li>White, etc.</li> </ul>	can Indian, Black,
er dea		1 Yes 2 No 1 Yes 2 No 1 Yes	2 X No specify:		Specify: Wh:	ito
urs afl tural'	d by	or Dates:	sual Occupation (Give kind of		16b. Kind of Business/l	
5 72 ho un "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	f working life. DO NOT use re			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	duc	5 Health	Care Execut		Health Ca	re Clinic
115-1 filed al Hyg ed oth	Be C	17. Father's Name (First, Middle, Last)  Richard Alvin Sconce		e (First, Middle, M Jean I		
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland seath and Mental Hygene. tiem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	To B		Iress (Street and Number or			, Zip Code)
MD id 2 sho lith and in 27 is		Debbie Sconce 5Della	Drive, Fent		souri 6302	26
nore, ages land nt of Heal it: If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other pl		Date	20c. Location - City or	
imo Page ment c		4 Donation 5 Other Specify: St. MarcusC	rematory 12	-2-10	St.Louis,	Missouri
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Pyggiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical					Funeral	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo	Harford Roade of dying, such as cardiac	ad, Balt or respiratory arre	<u>imore, Mar</u> est, shock, or heart	vland2121 Approximate Interval
(Viedical)		failure. List only one cause on each line.  Immediate Cause (Final disease a. Doxepin Intoxication				Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	7	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause				
ecuted and transit		events resulting in death) Last  Due to (or as a consequence of):  d.				
ਲ ਛੋਡ	edical	▼ UNPENDED ☐ AMENDED 23a,27,28a-f per	me g912 2-18-	-11 vt		
Box 68760, e death certificate by the attending physical for use as the but	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the second 1.2 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	eath 3 Ectopic pregna	ancy	23d. Date of delivery  Month	yay Year
ox 687 eath certific attending	icia	past 12 months?  4 Pregnant at time of death 5 Other (				
D. Bo t the deat by the at	Phy	Part II. Other significant conditions contributing to death but not resulting in the under	ving cause given in Part I	23e Did tol	bacco use contribute to	he cause of death?
P.C es that igned be deta	ē	The first of the f	ying dadad giroir iii r dici.		2 No 3 Prob	
cords, law requir has been s	Completed			24a. Was a		opsy findings available ompletion of cause of
Reco The law icate has	E O	1		perform 1 <b>V</b> Yes 2	med? death?	,
Vital Rey ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)		
· Vit		1 ✓ Yes 2 No Inospiral 1 Inpatient 2 ER/Outpatient 3			Residence 6 Other	Scene
n of \ding Phy. h. After tl		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day,Year)  5 Pending  Fd. 11—22—10 Fd. 1610bx	28c. Injury at Work?		ow injury occurred	
Division tal or Attendii rs after death. al Director: A	icati	2 Accident Investigation 2% Place of Injury At home form street for	. S	unknows 28f. Location (S	treet and Number or Rui	al Route Number, City
Div urs after rat Di	Certification:	Suicide 6 X Could not be determined (Specify) residence	3.	or Town, St	ate) 116 Walnury, Md. 21	St. Apt.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone)  2 Medical Examiner: On the basis of examination and/or investigation, in		due to the cause	e(s) and manner as state	d.
To To Com	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		(alyment 7' M)	O.C.M.E.		November 23, 20	10
_	1	30. Name and address of person who completed cause of death (Item 23a)				
			reet, Baltimore, MD 21	201		
St Regist	ate rar		alal			

DHMH 17 Rev 1/2001

Oursen A. Jakes

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 2010 David Thorton Small, Sr. 17:58 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Air 7. Age (In yrs. last birthday) Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours 06/18/1931 **Director** Maryland 213-28-5019 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Kingsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 7708 Buck Hill Road 21087 12. Was Decedent Ever in U.S. Armed Forces?

1 🛣 Yes 2 🗆 No If Yes, Give Kore Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. or i No Korean Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: Year or Dates. White Conflict traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 4 Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic any injury or other traumatic anoie, Robert C. Small Fannie Morisa Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (son) 2718 Old Joppa Road - Joppa, Maryland David T. Small, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/03/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by or Attending Physician; The law requires 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? performed Yes 2 1 Tes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of 0006912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive Bel Air, mo 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day Physician/ 1935 PM 27200 Malatiben Mahesh Suthar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Grove Adventist Hospita 8. Date of Birth (Month, Day, Year) 09-14-1944 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country)
India **Director** 217-96-1369 66 Usual Residence of Decedent 10a. State 10b. County 10d, Inside City Limits 10c. City. Town or Location or than "natural", or Items 23a or 28a-f sho the Me Ical Examiner must be notified at Director 1 Yes 2 X No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8804 Gingerbread Court 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. 9 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: Asian Indian If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic Kusumben Suthar Shantilal Ambaram Gajjar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8804 Gingerbread Court Gaithersburg, Maryland 20877 Mahesh A. Suthar / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Denation 5 ☐ Other (Specify) Arundel Crematory 12-02-2010 Odenton, Maryland Signature / Funeral Service License <sup>22. Name and Address of Facility</sup>
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Aspirotion

Due to (o as a consequence of Preumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner it any teating to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Tonque or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? nin 24 hours after death.

the Funeral Director: After this certificate I
npleted filled in by the funeral director, page 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aff Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier

25 State Registrar (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

an

m.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ms

32. Registrar's Signatu

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in their

9901

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D00655 05

Medical Car Dr Rockville MD 20850

November 28,2010

			State of M	aryland / Depa				2010	37020
			1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	<i>Jeaun</i>	2. Date of Deat	eg. No. 💪 🕖 🚶	3. Time of Death
	Physicia		Victoria Smith				Month 12		0 4:45 PM
~,	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	th
كمريد	/		Union Memorial Hospita		Baltim	ore		1	
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 M 2 18-78-6658	le (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec	9. Bir II, 1962 K	thplace (State or Foreign untry) laryland
			Usual Residence of Decedent					·	
	yland -f sho ed at	ctor	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits  1. □ Yes 2 □ No
	r 28a notifi	Director	10e. Street and Number	Baltim	10f. Zip Code		1 1	Og. Citizen of What Co	
	with the 23a c	Funeral	1102 Druid Hill Avenue A	pt. 1513	2120	)2		United	,
	items items		11. Marital Status 12. Was Decedent Armed Forces?		Vas Decedent of Hi Yes, specify Cuba			14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 Yes 2	No	☐ Yes 2 ☐ No	-		Specify:	Black
9	hours natura lical E	Completed	15. Decedent's Education		lent's Usual Occup		. T	16b. Kind of Business	Industry
215	iin 72 ie. han "ı e Med	dwo	(Specify only highest grade completed)  Elementary/Seconday (0-12)  12  College (1-4 or 1)	5+) life_ Do	of work done and NOT use retired)	luring most of work	ing		
2	d with tygier ther t	Be C	12 17. Father's Name (First, Middle, Last)	Но	me Maker	18. Mother's Nam	a (Firmh Adiabata Ad	Own Hom	e
and	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To E	Charles Smith				ly Morte		
Maryland 21215-0036	should and Ma is mar raumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Run	al Route Number,	City or Town, State, Zij	o Code)
	and 2 s Health a tem 27 i		Beverly Smith-Morten /Mot			Mall Road		ore, MD 21	
altimore,			20a. Method of Disposition 1 ☐ Burial 2. Cremation 3 ☐ Removal from State		natory or other plac	e) .	Dec 06	20c. Location - City or	Town, State  le, Maryland
븊	nit. Page artment o ortant: If injury or		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		eake Crem		2010	ernatives	ie, Maryrand
Ba	permit. Departn Importa any inju		Jula Sue Rith	MO(443 22				Towson Mary	yland 21286
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	d the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Ŧ	hysician/	0.0	Immediate Cause (Final disease or condition	PSis					Onset and Death
and the same	Medical Examiner		resulting in death)  Due to (or as	a consequence of):					25 years
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):					75 000
٥.	uted d ansit	Examiner	Cause (Disease or iinjury that initiated events						
b	exectian an	EX	resulting in death) Last Due to (or as	a consequence of):					
9	death certificate be executed he attending physician and ed for use as the burial-transit	edical	d						
89	pertific nding use as	n/M	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant	of pregnancy	1			23d. Date of de	livery
P.O. Box 687	requires that the death certifics been signed by the attending p should be detached for use as 's	by Physician/Me	in the past 12 months?  1  Yes 2 No  1 Ves 2 No	2 Fetal death 3 at time of death 5	Ctopic pregnance Other (specify)	У		Month	Day Year
0	it the o	Phy	9 Unknown  9 Unknown  Part II. Other significant conditions contributing to death t	out not resulting in the u	nderlying cause giv	ren in Part I	22a Did tob	acco use contribute to	the cause of death?
ω, σ.	res tha signec	d by	Part II. Other significant conditions contributing to death I	out not resulting in the d	ndonying cause giv	CITITI CITE.	1  Ye	11	robably 4 Unknown
ğ	requii been should	lete					24a. Was ar	24b. Were au	topsy findings available
Division of Vital Records,	he law te has age 2	Completed					autops perform 1 \(\sum \) Yes 2	ned? death?	completion of cause of s 2 □ No
a	isician: The la certificate ha lirector, page 2	Be C	25. Was case referred to medical examiner?			ace of Death (Chec		24(10)	
₹	Physic this ce al dire	유		ient 2 ER/Outpatien		4 L Nursing Ho		nce 6 Other (Spec	ify)
0	ding I th. After funer	cate	1 Natural 5 Pending (Month, Date 2 Accident Investigation		28c. Injury work M 1 🗆		28d. Describe ho	w injury occurred	
SIO	Atten er dear ector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm, stre				eet and Number or Ru	ral Route Number,
2	ital or irs afte ral Dir led in		building, et	с. (эреспу)			City or Town	otate)	1
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of a	examination and/or invest	igation, in my opinio	n, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated.
	To the within To the comple	_	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier		29c. License	number	25	9d. Date signed (Monti	n, Day, Year)
			→ MO		AT2	438941	5	12/01	12010
	4		30. Name and address of person who completed cause of a Maryam Keshtkar Tay	leath (Item 23a) (Type, P	rint) E ()	niv. Da	2KWAU	Battim	ore M212
			Maryary Kesnikar Ja	ar's Sandure		70.11. 1-00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7,000 (177()	18
	Stat Registra		31. Deterfied Month 2010 Per Senen 32. Respective	19					

			For	State of Maryland / Depart	artment of Health and		ne <b>Legibic.</b>	
	_		State Registrar  1. Decedent's Name (First, Middle, Las		rtificate of Death	Reg.	No.2 0 1 0	37840
	Physicia Medic		Charles	Spivey	(	2. Date of Death	21, 2010	3. Time of Death B. 45 Am
9	Examin	er	4a. Facility Name (if not institution, give Famond So.	n Ave. Act. 308	4b. City, Town, or Location of Deat	th	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se 244 - 210 - 3605 2	7. Age (In yrs last birthday)  7. Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birth	place (State or Foreign http)
and	show 1 at	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
ne Maryl	or 28a-f notified	Director	MD N/A  10e. Street and Number	Baltimore	10f. Zip Code	100	Citizen of What Cou	1 Yes 2 □ No
h with th	ns 23a c must be	Funeral	1700 Edmonds		21233	U	SA	
<b>21215-0036</b> within 72 hours after death with the Maryland	ral", or items 23a or 28a-f show Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married	1 Vos 2 INO	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify:	
<b>21215-0036</b> within 72 hours after		Completed	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra	de completed) (Give	dent's Usual Occupation kind of work done during most of wo	rkina 16b	b. Kind of Business In	ndustry
<b>2121</b> within 7	Hygiene. other than ent, the Me		Elementary/Seconday (0-12)	College (1-4 or 5+)	ONOT use retired)	3	hip Yara	d
land be filed	ental rked ic ev	To Be	17. Father's Name (First, Middle, Last)		18-Mother's Na	me (First, Middle, Maid GOVP)	en Surname)	
Mary 2 should	lith and M 27 is mai r traumat		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mailir	ng Address (Street and Number or Ru	ural Route Number, City		code) MD 21223
	\$ = P		20a. Method of Disposition  1 Burial 2 Cremation 3		osition (Name of matory or other place)		. Location - City or T	own, State
Baltimore,	artmer ortant injury e.		4 ☐ Donation 5 ☐ Other (Specification of Specification) 5 ☐ Other (Specification) 5 ☐ Other (Sp	1 11 - 141	1 CTICLEY 1-0 ENergia and Address of Facility L	Funeral H	institutioner Iome P.A.	Min
<b>m</b> 8	lmp any any		23a Pol 1 February the disease or comme	Olications that caused the death. Do not enter	er the mode of dying such as cardia	PASS Ba	Ito. MD 5	Approximate
	ysician/		shook, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	OBSTRUCTION	or respiratory arrest,		Interval Between Onset and Death
1.5	Medical caminer		resulting in death)	Due to (or as a consequence of):	ubol/15m			
p	ısit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of):	FAILURE			
be executed	ysician and e burial-trans <b>it</b>	ical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence of):	10110000			
	g physic as the b	Medic	re service	d				
<b>Box</b> death	has been signed by the attending phys je 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  4  Pregnant at time of death 5  9  Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliving Month	very Day Year
cords, P.O. law requires that the	gned by	by Ph	Part II. Other significant conditions co	entributing to death but not resulting in the u	underlying cause given in Part I.		o use contribute to t	
ords,	been sig	leted	HEPANOCELL	ULAR CANCER		1 ☐ Yes	24b. Were auto	obably 4 Unknown
Rec	cate has page 2					autopsy performed 1 \(\sum \) Yes 2 \(\overline{\overlin		ompletion of cause of
<b>Vital</b> ysician	this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death (Che	eck only one)  Home 5 Residence	6 ☐ Other (Specif	v)
Division of Vital Records,	within 24 nours arer death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page	cate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how in		
ivisic	within 24 hours after death.  To the Funeral Director. After completed filled in by the funer	Medical Certificate:	3 Suicide 6 Could not be 4 Homicide determined		eet, factory, office	28f. Location (Street City or Town, Sta		l Route Number,
To the Hospital	Z4 nours Funeral sted filled	edical	(Check 2   Medical Examin	ician: To the best of my knowledge, death oner: On the basis of examination and/or investigation.	tigation, in my opinion, death occurred	at the time, date and pla	ace, and due to the ca	ause(s) and manner stated.
To the	witnin <b>To the</b> сопрЫ		29b. Signature and title of certifier	e Practioner: To the best of my knowledge, o	29c. License number	29d.	Date signed (Month,	Day, Year)
	2	-	30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, F	Print) Suite LLIO	3455 141	KENS AV	24,2016 E.
	Stat	e	RHTWANI 31. Date filed (Month, Day, Year)		•	BALTIMOR	E, MD	21229
	Registra		DEC 0 3 2010	32. Registrar's Signature				

#### All Copies Are Legible.

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riease Type of First in Black indelible link. Ensure All Copies Are i
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar Ce.	rtificate o	f Death	mai riygiono	Reg. No.	37841	
Physic Medical Exan		Decedent's Name (First, Middle,Last)		7	2. Date of E Month Novemb		3. Time of Death 2230 hrs	
		4a. Facility Name (if not institution, give street and number) 7313 Grove Road Suite R		4b. City, Town, or Location		4c. County of Dea	th	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)	If Under 1 Year If Un	der 24Hrs. 8. Date of	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or		
Directo	r	213-80-3240 1 AM 2 F 36	Yrs	Months Days Hou	rs Min. Sept	18 1974 Fore	ountry) MD	
'any			, Town or Locati				10d. Inside City Limits	
yland -f show	ğ	MD Washington Rol	hrersvi				1 Yes 2 X No	
he Mari or 28a	Director	10e. Street and Number 3116 Valley View Court		10f. Zip Code 21779		10g. Citizen of What Co	untry?	
h with t ms 23a	uneral	11. Marital Status  12. Was Decedent Ever in U. Armed Forces?		s Decedent of Hispanic Or	igin? ( Specify Yes or		rican Indian, Black,	
ter deat	Fun	1 Never Married 2 Married Armed Forces?   1 Yes 2 No   3 Widowed 4 Divorced If Yes, Give Year		es, specify Cuban, Mexica  Yes 2 No specify		White, etc. Specify: Whi	te	
nours af natural	od be	or Dates:	16a. Deceden	t's Usual Occupation (Give	kind of work done	16b. Kind of Business		
<b>AD 21215-0036</b> 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she mustic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  4		ost of working life. DO NO Ness owner	I use retired)	mortgage		
5-00 lied wit Hygien lother the Me	Con	17. Father's Name (First, Middle, Last)			er's Name (First, Middle			
21215-0036 ould be filed within 7 I Mental Hygiene. s marked other than ic event, the Medica	To Be	Gary Stone 19a. Informant's Name/Relationship (Type, Print)	10h Mailing	Cat.	herine Haj	OS lumber, City or Town, State	<del>-</del>	
e, MD ;	-	Loren Stone (spouse)	5208 H	Bamburg Ct.,			e, Zip Code)	
S II I		1 X Burial 2 Cremation 3 Removal from State	crematory or oth	tion (Name of cemetery, er place) Ld Cemetery	Date 12-2-10	20c. Location - City of		
Baltimo permit. Page Department or Important: injury or oth	П	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee				Sykesville nera ome		
		Pain Haight Herbert	P.0	O. Box 195 S	ykesville,	MD 21784	maper	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.				arrest, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Asphyxia Due  Due to (or as a consequence of		aration of 1	loxic Gas		Dodur	
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	f):					
=	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	f):					
xecuted n and l - trans		d.  X UNPENDED 23a 27	00 5	010	10 07 10			
760, icate be executed physician and the burial - transit	Medical	IF FEMALE: 23c If yes outcome of preen		per me g910	12-27-10 v	23d. Date of deliver		
c 68760, certificate bending physicuse as the bu		23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of dea	2 Feta	al death 3 Ectopi	c pregnancy		Day Year	
Box 687.  he death certifing the attending hed for use as t	Physician	1 Yes 2 No 9 Unknown g Unknown	5 Oth	er (Specify)		<u> </u>	1	
P.O. ss that the gened by e detac	by	Part II. Other significant conditions contributing to death but not re-	sulting in the un	iderlying cause given in Pa		tobacco use contribute to es 2 No 3 Prot	the cause of death?	
Division of Vital Records, tal or Attending Physician: The law require rs after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed				24a. Was	s an 24b. Were au	topsy findings available completion of cause of	
II Recc	Som					form <u>ed</u> ? death?		
/ital Re sician: The is certificate lirector, page	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2	ER/Outpatient	26.Place of Death  3 DOA Other	1 -	Decidence of Control		
of \frac{1}{\text{ing Phy}}	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Inj			Residence 6 Other how injury occurred	: Scene	
Sior Attend r death. ector: by the f	catic	Pending Investigation Fd 11-26-10 E	d 10:15		unknor			
Div	Certification:	Suicide 6 X Could not be determined (Specify) workpla		, ractory, office building, et	or Town,	(Street and Number or Ru State) 7313 Gro R, Frederick	ve Rd.	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and	e, death occurre	ed at the time, date and pla	sce, and due to the cau	use(s) and manner as state	ed.	
To t To t	led.	and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor		
	2						in, Dary, rear)	
		Panel Southall MM		O.C.M.E.		November 27, 20	. ,	
		January Southall, WIJ  30. Name and address of person who completed cause of death (Item 2 Pamela E. Southall, MD Assistant Medical Example)	,	O.C.M.E. Penn Street, Baltim	ore. MD 21201	November 27, 20	,	

			For State		State of	Marylan					and M	lental Hy	giene	010		010
			Registrar		-1		Cer	tificate	of D	eath			Reg. No.	UIU	31	046
	Physicia	an/	1. Decedent's Name (Firs		,	0-11						2. Date of De _Month	ath Da <u>v</u>	Year	3. Time o	
-	Medi Examir		Richard  4a. Facility Name (if not in		gene street and numbe	Sell		45 Oiby T			15:46	Novem		9, 201		0 A M
	LXAIIN	iei	981 Top Vi			'/			own, or EWOC	Location o	t Death		4c. Co	ounty of Deat		
	Funeral		5. Social Security Number	6. 5	Sex 7.	Age (In yrs. la	ist birthday)	If Under 1	1 Year	JCI If Under 2	24 Hrs.	8. Date of Birt	th	arford	thplace (State	or Foreign
	Director		212-38-461	6	<b>№</b> м 2 🗆 ғ	68	Yrs.	Months	Days	Hours	Min.	09/14	1942	Ma	ryland	or roleigh
	nd now	٦	Usual Residence of Deced	County		100 Cit	. Town or Las	-41-								
	arylar a-fsh	<b>Funeral Director</b>	MD	Harfo	w.J		, Town or Loc								10d. Inside C	
	or 28	ä	10e. Street and Number	пагто	rt d		Edgewo	001 10f, Zip (	Code			Т	10 0"	4447		s 2 🛭 No
	with t 23a st be	eral	981 Top Vie	ew Dri	Ve				040			-		n of What Co	untry?	
	eath tems er mu	Ē	11. Marital Status	<u> </u>	12. Was Deceder	nt Ever in U.S	. 13. W			panic Orig	in? (Spec	cify Yes or No-		S.A.	rican Indian	
36	fter d ", or i amin	ρ	1 Never Married 2		Armed Forces	s? □ No	l II	Yes, specify	y Cuban	, Mexican,	Puèrto F	Rican, etc.)	1,4.	Black, White		
8	iurs a tural' al Exi	ted	3 Widowed 4 D		If Yes, Give Year or Dates		1	Yes 2	LX No	Specify:			Spe	ecify:	White	
15-	72 ho n "na ledic	Completed	(Specify or		ducation ade completed)		16a. Decede (Give k	ind of work	done du	tion ing most	of workin	ng	16b. Kind	of Business	ndustry	
12	vithin iene.	ပ်	Elementary/Seconday  Q	(0-12)	College (1-4 c	or 5+)		NOT use re								
b	iled v al Hyg othe rent,	Be	17. Father's Name (First, M	fiddle, Last)			COII	<u>crete</u>			r's Name	(First, Middle,		<u>onstru</u>	Ction	
Maryland 21215-0036	d be f Menta Menta arked arked	မ	Edgar		Sell						nerin		maiden oun	Shvr	ock	
lan	shoul and I is ma		19a. Informant's Name/Re	elationship (7	ype, Print)		19b. Mailing	g Address (S	Street an			Route Number	; City or Tou			
≥ ′	nd 2 lealth m 27		Dorothy Se		ife		1					Edgewoo				
Ore	ge 1 and the strate of the str		20a. Method of Disposition 1  Burial 2  Cre	mation 3	Removal from Sta	20b. Plate	ace of Dispos metery, crem			)		ate		ion - City or		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		4 🛮 Donation 5 🗆	Other (Speci	5/)	Ana	tany Gif					L/2010				đ
Bal	permi Depar Impo any ir		21. Signature of F ral S	ervic Licens	е		22.	Name and	Address	of Facility	Ana	atomy G	ifts I	Regist	ry	
		Н	23a. Part 1. Enter the disc	ase or com	plications that cause	ed the death	Do not onton	522 CC	onne	TTey	Dr.,	Ste.	P, Har	nover,	MD 21	076
١,	141		shock, or heart failure Immediate Cause (Final	e. List only o	ne cause on each li	ine	. Do not enter	the mode o	or wing,	such as ca	ardire or	respiratory arre	est,		Approximat Interval Bet	ween
	Physician/ Medical		disease or condition resulting in death)		a	s conseque	teis te	the	(0	nj	10	ncen	*		Onset and I	/h
	Examiner				Due to (or a	s a conseque	nice or).			0						
		Examiner	Sequentially list condition if any, reading to immediate cause. Enter Underlying	s,	b. Due to (or a	s a conseque	nce oij.									
2.	outed nd ransit	kam	Cause (Disease or linjury that initiated events	7	C											
	e exe	alE	resulting in death) Last		Due to (or a	s a conseque	ence of):									
200	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and i in by the funeral director, page 2 should be detached for use as the burial-transit	edical			d											
189	ath certifica attending p	Š	IF FEMALE: 23b. Was decedent pregna		23c. If yes, outcom	e of pregnanc	CV									
Box 687	atten for u	iciai	in the past 12 months  1 Yes 2 No		1 Live Birth 4 Pregnant	2 🗌 Fetal	death 3	Ectopic pred					23d.	Date of deliver Month		⁄ear
Э.	the de sy the achec	hys	g Unknown		9 🗌 Unknown											
P.O.	requires that the de been signed by the should be detached	by Physician/Me	Part II. Other significant c	onditions co	entributing to death	but not resul	ting in the und	derlying cau	use giver	in Part I.		23e. Did tot	pacco use c	ontribute to t	he cause of de	eath?
ds,	quires en siç ould b	ted	- Hary	45	lle lliky	<u> </u>						1 1	es 2 🗆 N	o 3 🗆 Pro	bably 4 🗌 t	Jnknown
CO	aw re las be	Completed	Hypate	2518	<u>م</u>							24a. Was ar autops		b. Were auto	psy findings a	vailable
Division of Vital Records,	sician: The law certificate has the law lirector, page 2 s	် ပြ										perform	ned?	death?	1 -	ause oi
ţa.	nysician; nis certific director,	m	25. Was case referred to me examiner?		Hospital:				7	e of Death	(Check o					
<u> </u>	Phys	은	1 Yes 2 No		1 Inpa 28a. Date of inj		R/Outpatient 8b. Time of					e 5 Reside			0	
ם :	nding ith. : After s fune	Certificate:	1 Natural 5	Pending Investigation	(Month, Da	ay, Year)	injury		Injury at work?	t s 2 □ N		d. Describe ho	w injury occ	urred		
isio	Atter	۱∄	3 Suicide 6 🗆	Could not be determined	28e. Place of In	jury - At hom	e, farm, stree			5 2 11	_	f. Location (Str	eet and Nur	mher or Pum	I Pouto Numbe	0.5
2	tal or		. E. rismide	Jeterninied	building, e	tc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			120	City or Town	, State)	riber or nura	noute Numbe	<i>∋r</i> ,
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier 1 Cer (Check 2 Med	tifying Phys	ician: To the best o	f my knowled	lge, death occ	cured at the	time, da	ate and pla	ice, and	due to the caus	se(s) and ma	nner as state	ed.	
	the Print 24		only only	diying runs	er: On the basis of Practioner: To the	examination a best of my k	na/or investiga nowledge, dea	ation, in my o ath occurred	opinion, at the tir	death occu me, date ar	irred at th nd place,	e time, date and and due to the	d place, and cause(s) and	due to the ca manner as st	use(s) and man ated.	ner stated.
_	S 5 ₹ 5	ľ	29b. Signature and title of	ertifier		1			cense nu			2/	d. Date sig	ned (Month,	Day, Year)	
	4	-	00/6		TO FA	U		t	15	102	2	/	Voven	Jin 3	0 20	10
	$\varphi$		Name and address of po	orson who co	ompleted cause of o	death (Item 2		it)		5 1		11/ 1	5/.	/	1.	
	State		1. Date filed (Month, Day, Y	(ear)	32. Regis	ay's Signatur	0 170	(suf	7	erre	~ (	vay e	yeu	ie W	10 711	040
	Registra		DEC 0 3 20	110 4	with the	1. 40	Ch. Alian									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Peter L. Sullivan Nov 30, 2010 Year 4:53 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death **Ellicott City** Howard 5137 Bonnie Branch Rd Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Nov 2, 1932 102 M 2 🗆 F Months Davs Hours Min. 023-26-5267 78 Director MA Usual Residence of Decedent ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Howard **Ellicott City** 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5137 Bonnie Branch Rd. 21043 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?, 11/6/1954 Yes 2 No 11/6/1954 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 2/ No 1 Yes Specify: 3 → Widowed 4 □ Divorced 11/6/1957 Specify. Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work auric life. DO NOT use retired) Writer (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Writing traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Frank E. Sullivan Florence E. Lancey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Sullivan Son 5137 Bonnie Branch Rd. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, LLC 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cross Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Cremation 3 - Removal from State Nov 30, 2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 of Funer rvice Licenses se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Friter the dis Approximate Interval Between Onset and Death shock, or heart failure. . List only one cause on each line. Immediate Cause (Final disease or condition Pnysician Chronic Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been s', page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No s after death.

| Director: After this certificate 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Hospital: 2 No ပု 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident М Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier OXI

State Registrar Marter

1070

32. Registrar's Signature

Columbia MD 21044

310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chuidia

31. Date filed (Month, Day, Year) **DEC** 0 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DOM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner C. County of Dealt If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday If Unde (Month, Day, Year) Jun 25, 1946 1 🛛 M 2 □ F Min. 189-36-0326 64 PA Yrs **Director** Usual Residence of Decedent or 28a-f show . Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hyglene. Hant: If flew 27, is marked other than "natural", or items 23a or 28a-f sho into rother traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. inside City Limits Director MD Anne Arundel Millersville 1 Tyes 2 R No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 499 Kenora Dr. 21108 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2/10 No Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced 4 Divorced Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Joseph Smith **Dorothy Mae Sheets** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie E. Smith Spouse 499 Kenora Dr. Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 1 🗆 Burial 2 🗗 Cremation 3 🗆 Removal from State Dec 06, 2010 Atlantic Crematory, LLC Glen Burnie, MD 4 Donation 5 Other (Specify) and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral Set 101243 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a c) insequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examine been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ongestive Heart Failure deu to diastolic dysfunction 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Mellitus 24a. Was an Diabetes has autopsy performed? after death.

Director: After this certificate Uper lipidemia 2 🗆 No 20 N 25. Was cas: r ferred to edical funeral director, Certificate: To Be 26. Place of Death (Check only one) examine 1 2 No Other 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MD 7556 Teaque Koa Hanover UTKOWSK

State Registrar Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - State C Registrar	of Marylan	-	artment of F <i>tificate of E</i>	lealth and M Death		giene Reg. No.	10	37845	
	Physicia		Decedent's Name (First, Middle, Last)	e Scho	enemann		2. Date of Death Month Day 2010		3. Time of Death 3:30 Р. м			
ا	Medic Examin		4a. Facility Name (if not institution, give street and nur Charlestown Nursing Ho		**	r Location of Death 4c.			County of Death Baltimore			
<b>~</b>	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	th y, Year) 1921 Mary Land		olace (State or Foreign try) 1and			
	Aaryland 8a-f show tified at	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	1 1	, Town or Loo						0d. Inside City Limits 1 ☐ Yes 2 🏝 No	
<b>1036</b> rs after death with the N	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Immortant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number  709 Maiden Choice Lan  11. Marital Status  12. Was Dec				10f. Zip Code  21228  Jas Decedent of Hispanic Origin? (Specify Yes or No-			10g. Citizen of What Country?  U.S.A.  No- 14. Race - American Indian,		
	urs after de: tural", or ite al Examiner	즐	1 Never Married 2 Married 1 Yes 3 Xwidowed 4 Divorced Armed F.	orces? 2 🛣 No ve	No -		dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)  2 No Specify:		Bla Specify	Black, White, etc.  Specify: White  b. Kind of Business Industry  Own Home		
21215-0036	within 72 ho giene. er than "nat , the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  12th  College (1)	e completed) (		ent's Usual Occupa kind of work done d D NOT use retired) nemaker	ation uring most of workir	ing				
Maryland	d be filed of Mental Hyg arked other atic event,	To Be	17. Father's Name (First, Middle, Last) Herman	Ĺ	18. Mother's Name (First, Middle, Maiden Surname)  Katherine Raber							
, Mar	nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relationship (Type, Print) William Schoenemann Jr		315	g Address (Street and Number or Rural Route Number, City or Town, State, Z Ardmore Road Linthicum, Maryla				rylan	1 21090	
altımore,	t. Page 1 al tment of H tant: If itel ijury or oth		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  cemetery, crematory or other place)  Cedar Hill Cemetery 12/03/2010 Ba								Maryland	
Bal	21. Signed re of Funeral Service Licensee  22. Name and Address of Facility Gonce Funeral Service  4001 Ritchie Highway Baltimore, Mar  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								ervice , Mary	land 21225		
À	Medical Examiner  Street on executed the private street on executed the private street of the private street on the private street o	edical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):									
DOX DO	the attending planting for use as the	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown 9 Unknown	Ectopic pregnanc	y		1	ate of delive	ery Day Year			
US, T.C.	en signed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1  Yes 2 No 3									
Vital Records,	icate has be page 2 sho	Completed	autopsy prior to death								osy findings available inpletion of cause of	
וו סו אונש	The nopped of Attending Privacian, the law requires that the death certification within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	cate: To Be	27. Manner of Death 28a. Date	Inpatient 2  of injury	ER/Outpatien 28b. Time of injury	of 28c. Injury at 28d. Describe how injury occurred						
UIVISION	s after dea	I Certificate:	3 Suicide 6 Could not be	e of Injury - At hor ing, etc. (Specify)						Number or Rural Route Number,		
	within 24 hour	Medical	29a. Certifier (Check 2 Medical Examiner: On the base) 3 Certifying Nurse Practioner: 29b. Signature and title of certifier	sis of examination To the best of my	and/or invest knowledge, d	igation, in my opinio leath occurred at the 29c. License	n, death occurred at time, date and place number	the time, date a	nd place, and du e cause(s) and m 29d. Date signe	ue to the cau nanner as sta ed (Month, D	se(s) and manner stated. sted. Day, Year)	
	6		30. Name and address of person who completed cau	se of death (Item	23a) (Type, P	Macd	en Obi	ice Co	anc	Car	Em OR G	
	Stat Registra	te	31. Date filed (Month, Day, Year) 32. F	Registrar's Signat	ure Tipeland	. /					2/22	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TAYLOR Physician/ 606 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Te 4c. County of Death JOHNSHOPKINSTBAY VIEW MEDI ISACT NOPE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours 20 Country) Director Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10d. Inside City Limits Director 1 X Yes 2 I No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", 3 N Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DQ NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code 1a 20a. Method of Disposition 20b. Place of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 Donati 21. Sign were of Funeral Service Lie any 1d. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval/Betwee Immediate Cause (Final ind Death VASWLAG Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MAGOLIE earc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner attending physician and for use as the burial-transi Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown s been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe After this certificate 2 🗌 No 220 N 1 L Yes 25. Was case referred to medical examiner?

1 Yes 2 \sum No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ,0 29d, Date signed (Month, Day, Year,

State Registrar 31. Date filed (Month, Day, Year)

DEC

3 2010

DHMH 17 Rev 7/2009

32. Registrar's Signature

Easter.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 29, 2010 TERESA LYNN TESTERMAN 10:41 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months Days Hours Min Feb. 2, 1956 213-60-6252 54 Maryland **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3715 Longley Road 21009 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 K Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene. Harford County Elementary/Seconday (0-12) College (1-4 or 5+) Correction Officer Sheriffs Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mari Belle Isenock James Wheeler Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverley A. Foard / Sister 12989 Oakland Road, Ridgely, MD 21660 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i other! 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place) Centre U.M. Church Cem 12-2-10 Forest Hill, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility McComas Funeral Home, P.A. 1217 Cokesbury <u>Road</u>, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ocard disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate has completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examiner: To the best of examiner: To the best of the mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) 2016 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapenter Da To LICMC 32. Registra Signat

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ nom 4 Medical Cility Name (if not institution) **Examiner** City, Town, or Location of Death 4c. County of Death
Baltimore Pasons andallStown **Funeral** 7. Age (In yrs last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Month, Day Director Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Baltimore MD NIA 1 Yes 2 □ No 10e. Street and Numbe ō 10f. Zip Code Stricker 10g. Citizen of What Country? Funeral 23a 21223 USA items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status er than "natural", or iter the Medical Examiner Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/S nday (9-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other t Be Father's Name Mother's Name (First, Middle, Maiden Surname) 2 Helena injury or other traumatic nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
320 N STYICKER ST. ROJHO MD 21223 Thomas f Health Stricker Botto mo 20a. Method of Disposition Department of H Important: If ite any injury or otl 20b. Place of Disposition (Name of 20g. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. 21. Signature of Fineral Service Visionse Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition rebra Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Due to (or as a consequence of) Exami attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law lequires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No Month Yes Day Year bate has been signed by the page 2 should be detached g Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy perform this certificate Yes 2 N Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 . Manner of Death Certificate: . Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death. To the Funeral Director, After 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes the Accident Investigation 2 🗌 No Suicide 6 Could not be completed filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number

State Registrar 30. Name and address of perso

who completed cause of death (Item 23a) (Type, Print)

32. Registrant Signa

693

10-09006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robin Tireese Tilsdale State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Robin Tireese Tisdale 3. Time of Death Month Day November 23, 2010 Medical Examiner 1912 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1936 West Fairmont Avenue Baltimore NIA 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Country) Director 212-70-6708 2 V F 1 M maryland Usual Residence of Decedent iny 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked uther than "natural", nr items 23a nr 28a-f she or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10g. Citizen of What Country? 1936 11 mount 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 10lar 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ۾ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) Baltimore, MD 21215-0036 NIA OFFICER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Oneic 115 dale mabel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silerton Rd. # 10 Andrea Jennings Larsdonne, md. 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 22. Name and Address of Facility 270 Staff ature of Funeral Service Lice nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physiciar Between Onset and /Medical Death Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease *saminer* or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tra Physician/Medical UNPENDED AMPNOTPER ME g910 12/9/10 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 🗸 Other: Scene ဥ 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural 1 Yes 2 No Pending 2 \_\_\_ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

 $\psi$ 

State Registrar 29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Date of Section 1)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OCME

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 24, 2010

			For State	State of Marylan				and Me	ntal Hygi	iene	07050
		1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death									1 3/830
	Physicia Medic		MALVINA THUMP	Day Year Year <b>29 200</b>							
200	Examin	er	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  JOHNS HUPKINS BAYVIEW MEDICAL CENTER  BALTIMURE							4c. County of De	eath
	Funeral Director		5. Social Security Number 6. Se 220-42-8666 1	7. Age ( <i>In yrs. la</i>	st birthday) Yrs.	If Under 1 Ye Months Da			Date of Birth (Month, Day,	<sup>Y</sup> <b>1</b> 946	Birthplace (State or Foreign Country) MD
	d st sow	Ŀ	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	ation					10d. Inside City Limits
	arylar a-f sk ified a	ecto	MD		ltimo						1 ☑ Yes 2 ☐ No
	with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 2503 Violet Ave	e.Apt.910-Sc	uth	10f. Zip Cod	1215		1	0g. Citizen of What 0	Country?
980	s after death rall, or items	ed by Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.	If		of Hispanic Orig uban, Mexican No Specify:			14. Race - An Black, Wh Specify: B1	
21215-0036	ithin 72 hour ene. • than "natu he Medical	Completed by	15. Decedent's Ec (Specify only highest gre Elementary/Seconday (0-12)	completed)  College (1-4 or 5+)	(Give k life. DC	NOT use retir	ne during most	of working		16b. Kind of Busines	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be (	17. Father's Name (First, Middle, Last)  James Gree	<u>4 yrs</u> ne	<u> </u>	PN		er's Name (F.		laiden Surname)	11400
Maryland			19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailin 2301	g Address (Stre	eet and Numbe	r or Rural Ro	oute Number, (	City or Town, State, . Balto, Md	Zip Code) • 21225
Baltimore,			20a. Method of Disposition  1 Description   1 Description   2 Description   3 Description   3 Description   5	Removal from State	emeterv. crem	sition (Name of atory or other p	olace) Cem. D	Date ec.1		20c. Location - City Dunda	or Town, State
Balti	permit. Departn Importa any inju		2 In nature of Funeral Service Licens		22 C	Name and Adal Vin 412 E	dress of Facility B. SC	rugg	s Fune St. Ba	eral Hom	e 21213
		7	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the death	. Do not ente	r the mode of o	dying, such as o	cardiac or re	espiratory arres	st,	Approximate Interval Between
8	Pnysician/ Medical	8 8	Immediate Cause (Final disease or condition resulting in death)  a. SEPSIS  Due to (or as a consequence of):								Onset and Death
1	Examiner										4 DAYS
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequ	Due to (or as a consequence of):						
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence d.	ence of):						
6876	tificat ing ph	Мес	IF FEMALE:								
Box 6	e death certifica the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregn Other (specify				23d. Date of o	delivery Day Year
ls, P.O.	uires that the n signed by t Id be detach		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause	e given in Part I	i			to the cause of death?
Division of Vital Records,	The law require ate has been si page 2 should	Completed by	LUNG CANCER					_	24a. Was an autopsy perform	y prior to ned? death'	autopsy findings available o completion of cause of ? Yes 2 No
al	sician: The certificate irector, pag	Be C	25. Was case referred to medical examiner?			26	. Place of Deat	h (Check on			30 2/2/10
Ξ	Physic this ce	မ	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2   1	ER/Outpatien	3 🗆 DOA				nce 6 Other (Sp	ecify)
0 U	ding I th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	, w	njury at vork? ☐ Yes 2 ☐		I. Describe hov	v injury occurred	
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1	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Medical	(Check 2 Medical Exami	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or investi	gation, in my op	oinion, death oc	curred at the	time, date and	place, and due to th	e cause(s) and manner stated.
	To the with To the company		29b. Signature and title of certifier	MD			ense number	00		Od. Date signed (Mor	nth, Day, Year) 29 2010
			30. Name and address of person who c		, , , , ,	*	50		VI= 0	1021	
	Stat	6.	MARC LAR OCHELE, 1 31. Date filed (Month, Day, Year)	32. Registrar's Signati		ENOR	BALTER	MURE L	טרי 2	11224	
	Registra		DEC 032	2010 Deserve	A. 16	arkel			<u> </u>		

DHMH 17 Rev 7/2009

		1	State of Maryland / Dep State Amend Item 26 per verb., g910,1	artment of Health and 2/03/2010dhb	Mental Hyg	giene		
		ď	Registrar  1. Decedent's Name (First, Middle, Last)	runcate of Beatif	2. Date of Deat			
Physic		1	Robert Lee Urie Sr.		Month NOV	22 2010 / 50 P M		
Med Exam		•	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death		
. )		ı	3611 Dahlia Lane	MIddle Rive	er	Baltimore		
Funera			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min		rth 9. Birthplace (State or Foreig		
Directo	r	_ L	215-30-0636   ¹⅓M 2□F   76 Yrs.	Indiana Sayo Tiodro Inni		1934 MD		
nd how		- Н	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lot	ocation		10d. Inside City Limits		
arylar a-fsl	Director	3	MD Baltimore Midd	le River		1 ☐ Yes 2 V No		
he M or 28	ةً	5  -	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?		
with t	<u> </u>	5	3611 Dahlia Lane	21220		IISA		
eath tems	Funeral	3	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,		
36 fter of	<u>غ</u>	3	1 Never Married 2 M Married 1 Yes 2 No	1 Yes 2 No Specify:	to ritoan, etc.)			
15-0036 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed	3	Year or Dates.					
15- 72 hc	g	-	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo	S. Date of Birth   (Month, Day, Year)   9. Birthplace (State or Foreign Country)   MD   10g. Citizen of What Country?   USA   14. Race - American Indian, Black, White, etc.   Specify: White   16b. Kind of Business Industry   A&P			
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교 호수를 들	a a		17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, M	Maiden Surname)		
Maryland should be file and Mental 7 is marked or raumatic eve	₽	2	Bennie Urie	Madel	ine Dav	is		
Maryla 2 should be th and Men 27 is marke traumatic		ſ	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Re	ural Route Number,	City or Town, State, Zip Code)		
nd 2 sealth m 27 iner tra		L	Mary Urie /wife 3	611 Dahlia Lan	e Balti	more MD 21220		
ore, l		1	20a. Method of Disposition 1 ☐ Burjul (20b. Place of Disposition 3 ☐ Removal from State B 2371) 1 3 13	osition (Name of matory or other place) Crematory 11/	Date	,		
Lim Emeni trant:		1	4 Li Uphayori 5 Li Other (Specify)	Crematory 11/	24/10	Baltimore MD		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		- 1	NUMMER OF YORK	2. Name and Address of Facility 3	00 MAce	Ave. Balto. MD		
		+	Talkallo Lace	Connelly Fu	neral H	ome of Essex 21221		
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	Physician/Me	ŀ	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy		· ·		
Box ( death or the attent	Sic		1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month Day Year		
			Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	bacco use contribute to the cause of death?		
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ecc e law has l	a m				autops	prior to completion of cause of death?		
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on andin ath. rr. Aft	ficat	27. Manner of Death 12. Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Homicide  28a. Date of injury 28b. Time of injury 4 work? 1 Yes 2 No  28b. Time of injury 4 work? 1 Yes 2 No  28c. Injury at work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred						
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Division of Vital Recc for the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical		29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation)	stigation, in my opinion, death occurred	at the time, date and	d place, and due to the cause(s) and manner stated.		
ithin ithe	ž		only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and p		cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)		
F 3 F 8		ľ	Vanman 11- Ma		1			
5		-	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Baltin	7 80	11/25/2010		
.)		ľ	4920 Compbell Blyd	Baltin	2020	mp		
St	ate	3	31. Date filed (Month, Day, Year)   22. Registrar's Signature					
Regis	trar		DEC 0 3 2010 June 5. Jan	les .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Herta A. Vaught Month 12 4:15 P 2010 01 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Avondell Assisted Living Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 🗆 M 2 🗶 F Months Days Min. 1077671929 218-32-8901 Germany Yrs 81 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Bel Air 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 W. Ring Factory Rd. USA 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify 3 X Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Heinrich Altenberger Luise Arnodt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert H. Vaught / Son 6412 Ripe Apple Ln., Columbia, MD 21044 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State West Chester, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co. 12/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of runeral Service Lie 22. Name and Address of Facility Tarring-Cargo Funeral Home, 333 S. Parke St., Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final en-d-stong disease or condition resulting in death) Due to (or as a conseq nce of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an

permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is marrany injury or other. Physician Medical Examiner

and -trans

attending physician a for use as the burial-

page 2 should be detached for use

signed by

has

After this certificate

To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t

To the Hospital o within 24 hours aff To the Funeral Di

that the death certificate be executed

The law requires Records,

68760

Box (

P.O.

Division of Vital

Examiner

Completed by

Certificate: To Be

Medical

Physician/

Medical

Examiner

**Funeral** 

Director

28a-f show

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items 23a

"natural", or

al Hygiene, I other than "

Medical

filed within 72 hours after death

Maryland 21215-0036

Examiner must be notified at

Director

Funeral

þ

Completed

Be

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Physician/Medical

25. Was case referred to medical

5 Pending

Investigation 6 Could not be

300

5

2 31. Date filed (Month, Day, Year)

1 ☐ Yes 2 No

Manner of Death

Natural

☐ Accident ☐ Suicide

4 Homicide

26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 XOther (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗌 Yes 2 No

D 32271

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

autopsy perform

Yes

1 🗌 Yes

28f. Location (Street and Number or Rural Route Number,

Decuber 2, 2010

2 No

Assisted Living

29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Belair 22 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 18:17 M M Chaplewright tourmber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Muryland Modical Stimore Confes 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 11-28-1954 1 M 2 TF 219-62-3469 Yrs 56 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must have also injury or other traumatic event, the Medical Evaminar must have also 10h Count 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel Glen Bürnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8146 Cloverhurst Road 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Specify. Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Assistance Li</u>ving 12th grade year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Woodrow Newton Mary Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Johnny F. Gray-Cousin 4218 Mary Ridge Drive Randallstown, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Μt Carmel Cemetery 12-6-10 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Bakto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Jenticemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exami the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Syndrome 1 Yes 2 No 3 Probably 4 Unknown Kespiratory Distres page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diseas has autopsy berformed? After this certificate 2 No Yes 26. Place of Death (Check only one) upleted filled in by the funeral director. Be 25. Was case referred to medical examiner? Hospital Other: 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work' s after death. 1 🗌 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifie

State Registrar udia

31. Date filed (Month, Day, Year)

Greens

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

Baltimore,

32. Registrar's Signature

Darks

DHMH 17 Rev 7/2009

9/20

1275851255

Lydia Fisher

Movember 26 2010

			For		State	of Maryla				nd Mental Hy	giene	
	1 - State Certificate of Death Reg. No.									0-07051		
	Physicia	n/	1. Decedent's Nam	, , ,	,					2. Date of De Month		3. Time/of Death 4
	Medic	al	Angela Aretha Washington						November 29, 2010			
	Examin	er	4a. Facility Name (if Gilchr	rnot institution, giv rist Cent			e Care	4b. City, Town, or	Location of Tows		4c. County of D	
	Funeral		5. Social Security N	lumber 6.	Sex		s. last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. Date of Bir	rth g.	Birthplace (State or Foreign
	Director		217-82	-4610	1 □ M 2 💢 F		42 Yrs.	Months Days	Hours	Min. (Month, Da Mar	<sup>ay</sup> ,0 <sup>y</sup> fa <sup>ar)</sup> , 1968	Maryland
	7 A	١. ا	Usual Residence of	Decedent 10b. County		40-	0.1. T					10d. Inside City Limits
	ryland -f show ied at	<u>t</u>	10a. State	Tob. County		100.	City, Town or Lo Baltim					1 Ves 2 No
	or 28a notif	Director	10e. Street and Nur	mber			Baitim	10f. Zip Code		1	10g. Citizen of What	
	vith th			incheste	r St. Aı	ot. B		2121	.6			States
	filed within 72 hours after death with the Maryland al Hygiene. 4 other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral	11. Marital Status		12. Was Dec	edent Ever in		Was Decedent of H	spanic Origin	n? (Specify Yes or No-		merican Indian,
98	fter d ", or i amin	۾		ried 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 No	1	f Yes, specify Cuba □ Yes 2 🕱 No		ruerto nican, etc.)	Black, W Specify:	
21215-0036	2 hours aft "natural", dical Exa	Completed	3 🗌 Widowed	4 Divorced  15. Decedent's	Year or D							Black
7	72 hc n "na Aedio	鱼		ecify only highest g	rade completed		(Give	dent's Usual Occup kind of work done o O NOT use retired)		of working	16b. Kind of Busine	ess Industry
212	within jiene. er tha the l		Elementary/Sec 10		College (1	i-4 or 5+)	•	use Keepi	.ng		Domest	ics
b	filed valued of other value of other		17. Father's Name (	(First, Middle, Last)			-			's Name (First, Middle		
yla	should be filed within 72 hours and Mental Hygiene. is marked other than "natur aumatic event, the Medical.	욘	Unk	Unk					Do	rothy Mae S	Sheppard	
Maryland	JE S I		19a. Informant's Na Sharro		<i>Type, Print)</i> nan /Par	tner	1				er, City or Town, State,	Zip Code) more, MD 21216
	and leal leal her		20a. Method of Disi		nan /raz		o. Place of Dispo		ester			
nor	Page 1 nent of ant: If it ury or o		1 Burial 2	Cremation 3 [ 5 D Other (Spec			cemetery, crer	natory or other place		Dec 01 2010	, Beltsvi	lle, Maryland
Baltimore,	T T		21. Signature of Fu			MO		_		Funeral Alt		
ä	permit Depar Impor any in		Reber	cca He	rober	men	365	871 <u>7 Gre</u>	on and een Pas	tures Drive	ternatives e Towson Ma:	ryland 21286
			23a. Part 1. Enter to shock, or hea	the disease, or cor art failure. List only	nplications that one cause on ea	caused the de	eath. Do not ente	er the mode of dyin	g, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between
1	Physician/		Immediate Cause disease or condition	(Final	44500000	Fuse	LARGE	. B-co	1	LYMPHO	MA	Onset and Death ManthS
	Medical Examiner		resulting in death)	•		(or as a cons						
- 1		e	Sequentially list co	onditions,	b. Due to	(or as a cons	equence off:					
0.	red	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or	iinjury	Duo to	(0. 43 4 00110	0440/100 01/					
W	execur in and ial-tra	Exa	that initiated event resulting in death)		C. Due to	(or as a cons	equence of):	·				
<b>°</b> 09	the burial-transi	dical		•	d							
	rtifica ing ph e as th	100	IF FEMALE:		00- 15							
Box 687	ath ce	Completed by Physician/M	23b. Was decedent in the past 12	months?		Birth 2  F	etal death 3	Ectopic pregnand Other (specify)	у		23d. Date of Month	delivery Day Year
	the a	ysic	1 Yes 2 9 Unknown		9 Unk		or death of L					
P.O.	that the	Ş P	Part II. Other signif	ficant conditions	contributing to o	death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
S,	luires en sign uld be	ed	ACUTE	AND	CHRON	16 Pe	WAL F	AILUR	e	1 🗆	Yes 2 □ No 3 □	Probably 4 Unknown
Sor	as bee	blet								24a. Was	ppsy prior	autopsy findings available to completion of cause of
Rec	The la ate ha	Com									ormed? death	n? Yes 2 □ No
tal	cian: certific ector,	Be	25. Was case referr examiner?		Hospital:			Oth		(Check only one)		pecify HOSPICE
Ž	Physi this c	2	1 Yes 2 27. Manner of Deat		1 🗆 28a. Date		ER/Outpatier 28b. Time of	T 3 LI DOA	4 □ Nurs		idence 6 Other (Sp how injury occurred	pecify) ( IOSPICE
0 0	nding th. : After s fune	cate	1 Aatural 2 Accident	5 Pending Investigation	(Mor	nth, Day, Year)	injury	work	? Yes 2 □ N		now injury occurred	
Division of Vital Records,	Atter er dea ector by the	Certificate:	3 Suicide 4 Homicide	6 Could not determined	be 28e. Place	of Injury - At	home, farm, str	eet, factory, office			(Street and Number or	Rural Route Number,
Σį	tal or is after al Dir led in				Build	ing, etc. (Spe				City or To	wii, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 horurs after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier (Check 2	Medical Exar	niner: On the ba	sis of examina	tion and/or inves	tigation, in my opinio	on, death occi	urred at the time, date	ause(s) and manner as and place, and due to t	he cause(s) and manner stated.
	ithin 2 the orthe	ž	only one) 3 29b. Signature and		rse Practioner:	To the best of	my knowledge,	29c. License	number		he cause(s) and manner 29d. Date signed (Mo	onth. Day, Year)
	ĕ ≥ <b>≓</b> ŏ		1 2/	and-	41-	Alm	MO	De	463	60	NOVEMBE	2 30, 2010
	^		30. Name and addr	ress of person who	completed cau	se of death (It	em 23a) (Type, F	Print				2 30, 2010 2 1 204
	2		MICHA	EL ANA	KALICEM I	no 6	701 N.C	HAPLES	TREOT	BALTIMO	Re MD	21204
	Sta		31. Date filed (Mont		32. F	Registrar's Sig	nature					•
	Registr	alr	DEC O	3 2010 /	much	19.14	- W					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 EDWARD LEROY WATTS 24 12:10 PM 11 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL ALL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Yea Days Country) Maryland 1 **X** M 2 □ F Months Min. Yrs. 1935 Director 213-36-9355 75 Sep. Jsual Residence of Deceden 28a-f show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Harford Forest Hill ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 2268 Adv Road 21050 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō by 1 Never Married 2 Married かるの 42690 5 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ŧ, Superintendant Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Edward Thomas Watts Bertha Viola Grover uge 1 and 2 sho u-epartment of Health and important: If item 27 is mo-any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1464 Rock Ridge Road, Jarrettsville, Maryland 21084 Michael Watts / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Hilltop Services Corp. 12/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a consequence of) artery disease or condition resulting in death) 15 years Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No the 9 Unknown Unknown Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. has been signed I e 2 should be det 23e. Did tobacco use contribute to the cause of death? þ tailure 1 Yes 2 No 3 Probably 4 Unknown Completed disease Chronic Were autopsy findings available prior to completion of cause of death? leidner 24a. Was an , page 1 ☐ Yes 2 ☐ No After this certificate Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) xaminer? 1 X Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending Natural 5 Pending injury work? death. 2 No Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) \$69864 11/291 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goer Chesapeake Dr. Bel Air, MD 21014 Chizman 320 r MD 1 (mothe

State Registrar 31. Date filed (Month, Day, Year)

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FOWARD

32. Registrar's Signature

			State of Maryland / De State of Maryland / De	partment of Health and b per dr/fh,g910, l ertificate of Death	Mental Hygien 1 <b>2/03/2010d</b> Reg. 1	hb hb	37856				
	Physicia		1. Decedent's Name (First, Middle, Last)  GILBERT  WA-	TKINS	2. Date of Death 11	<b>/20/2010</b> Day Year 1 2	3. Time of Death				
Medical Examiner			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	h 4	4c. County of Death					
- Jack			Northwest rehab	Randallstow	n E	Baltimore Co.					
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 1 M 2 F 83 Yrs	Months Days Hours Min	8. Date of Birth	9. Birt 27 Mar	hplace (State or Foreign (MT) and				
	land show d at	~	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits				
	arylar a-f sh fied a	Director		Baltimore		ĺ	1 X Yes 2 □ No				
	or 28,	Dir	MD N/A		Citizen of What Co						
	with t	əral	2104 Pressbury St.	21217		U.S.A.					
	tems er mu	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer					
စ္တ	fter d , or i		1 Meyer Married 2 Married Armed Forces? 1 Meyer Married 2 Married If Yes 2 A No If Yes 2 If Yes 2 If Yes 2 If Yes 2 If Yes 2 If Yes 3 If	If Yes, specify Cuban, Mexican, Puert  1  Yes 2 No Specify:	o Hican, etc.)	Black, White	•				
8	hours after death with the Maryland natural", or items 23a or 28a-f shc lical Examiner must be notified at	ted	3 Wildowed 4 Divorced Year or Dates.			Specify: Bl	ack				
5	72 ho n "na ledic	nple	(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of wor to DO NOT use retired)	rking 16b.	16b. Kind of Business Industry					
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed by	Elementary/Seconday (0-12)   College (1-4 or 5+)	inter	P	rivate	Homes				
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ylaı	should be fil and Mental is marked raumatic ev	2	James Watkins	Pearl	Carr		· · · · · · · · · · · · · · · · · · ·				
Maryland	t and 2 should be of Health and Mentr fitem 27 is marked rother traumatic e			ailing Address (Street and Number or Ru			· · · · · · · · · · · · · · · · · · ·				
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Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of	3									
ä	permi Depar Impor any in	()	Va Dichich N. Williams	27 Name and Address of Facility Williams 2720 P. Fulton	Aver; Bait	imore,M	Be 21217				
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ı	nysician/	8 (1	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Character & Order of the Cause (Final disease or condition resulting in death)								
-	Medical Examiner										
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Box 687	eath certifice attending p for use as t	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death			23d. Date of deli Month	very Day Year				
ñ	e dea the a hed fi	Physician/M	1  Yes 2  No 4  Pregnant at time of death 9  Unknown	5 Other (specify)		World	Day Tour				
P.O.	r requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?				
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000	w req	olet	Dementia		24a. Was an		opsy findings available				
3ec	rsician: The law r s certificate has t lirector, page 2 s	Completed			autopsy performed? 1 Yes 24		ompletion of cause of				
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₹	Physic this ce ral direc	To	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		lome 5 Residence	6 ☐ Other (Speci	fy)				
Jol	ing P	ate:	27. Manner 1 eath 1 atural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury injury	y work?	28d. Describe how inju	28d. Describe how injury occurred					
sior	I or Attending after death. Director: After I in by the funer	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - 4t home farm.	M 1 Tyes 2 No	296 Location Street and Number of Purel Pouts Number						
Division of Vital Records,											
	Hospital 24 hours Funeral sted filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in	th occured at the time, date and place, a	and due to the cause(s) at the time, date and pla	and manner as stat	ted. ause(s) and manner stated.				
	To the F within 2 To the F complet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier,		ace, and due to the cause		stated.				
/	¥		Arul Uberai MA	100 LO 45	290. [		2010				
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	0.5	RAI	- MA				
			ANIZ LIBEROL MI	) 4419 FAL	LS KID	04117	21211				
	Stat Registra		31. Date filed (Month, Day, Year)  REC 0 3 2010  32. Registrar's Signature	Kad							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 30 Movember Physician/ 9:20 PM lilkins Medical 4a. Facility Name (if not institution, give street and number) , or Location of Death Examiner 4c. County of Death Ta imore Tanes If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Yrs Director ems 23a or 28a-f show r must be notified at 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Penrose 31223 <u> 2947</u> 12. Was Decedent Ever in U.S.
Armed Forces?

1 Eyes 2 No
If Yes, Give 3 43
Year or Dates. 1 - 31 - 46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12+4 stadian II Governmen T Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ Wilkins senevia winder or Rural Route Number, City or Town, State, Zio Code) 2121 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and 2242) Penrose ess (Street and Number tonewall tome eanna 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore 10-6-10 21. Signatu ral Service License 270 Fredhilto 22. Name and Address of Facility Þ h Funera Part 1 Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) weeks Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): that the death certificate be executed burial-transit the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ page 2 should be detached for i in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 🗌 No been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕏 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 No 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Hospital 2 No Other: ပ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year) ess of persor to completed cause of death (Item 23a) (Type, Print) 001 31. Date filed (Month, Day, Yelar 32. Registrar's Signature State Registrar ack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nhi 2010 2224 VAV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death altimore NN . Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min.  $Mav^{(Month, Day, Year)}$ 017-48-4944 Vietnam 61 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 No MD Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21061 1609 Manning Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: han "natural", o Medical Exan If Yes, Give Year or Dates Specify: Asian Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Dry Cleaning Manager Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Unknown Unknown other traumatic ge 1 and 2 should but of Health and Mer It of Health and Mer If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1609 Manning Road, Glen Burnie, MD 21061 Thomas Woodward Son Department of Hea. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/24/2010 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Hemorrhous Physician/ disease or condition resulting in death) Medical days Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Medical Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 U 9 Unknown Unknown ò signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed: has page 2 this certificate 1 Yes 2 No Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🔀 No 1 Tyes ပ္ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury **Natural** 5 Pending 1 Yes 2 No neral Director: A 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled i Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 9900 22 2010 30. Name and address of person who completed cause of death (Item. 23a) (Type, Print) Baltimore St 22 MA Μ. Coane S. Greeve Kenneth 2120 Registrar's Signal State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09:35AM Beverly Ann Young 02 RECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Mar. 24 Days Min 1 □ M 2 🕅 F 563-06-6766 46 964 Maryland Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall Baltimore MD 1 Yes 2 XNo 10f. Zip Code 21236 10e. Street and Number 10g. Citizen of What Country? Funeral 9005 Carlisle Avenue USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 ☐XNo FYes, Give 72 hours after Maryland 21215-0036 should be filed within אביייבר... n and Mental Hygiene. היייים other than "natural", 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired)
Information Technology Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) America's Remote Elementary/Seconday (0-12) College (1-4 or 5+) Help Desk 12 Be 18. Mother's Name (First, Middle, Mair Ferbie Jean King 17. Father's Name (First, Middle, Last) Maiden Sumame ည Coy Nolan Paris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21236 19a. Informant's Name/Relationship (Type, Print) 9005 Carlisle Avenue-Perry Hall, Maryland f Health Mark Young-spouse other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec.6,2010 5 1 Surial 2 Cremation 3 Removal from State Gafdens Color Fathen Rossville,Maryland 4 Donation 5 Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral 8800 Harford l Chapel and Road-Parkvi ondra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADENOCARCINOMA OF LUNG disease or condition a METASTATIC Medical resulting in death) **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 X No
9 Unknown Pregnant at time of death Month ed by the a 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available cate has I autonsy prior to completion of cause of death? this certificate Yes 1 Yes : After this certification and area director, p Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No death. Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D 31826 mt 12-2-10 rared

DHMH 17 Rev 7/2009

State Registrar 7601 OSLERDANE TOWSON MARYLAND

M.D.

32. Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD L. LINTHICUM

31. Date filed (Month, Day, Year) **DEC** 0 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 2010 DECEMBER Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** stown Kanda TOS 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Country) 1 M 2 F Director 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County 10a State traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 2111 05 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, 19a, Informant's Name/Relationship (Type, Print) ushua or other Baltimore, tion - City or Town, State 20b. Place of Disposition (Name of 20c. L6 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) injury 22. Name and Address of Facility VIVA Greene Funeral Services 21. Signature of Funeral Service License any ndallstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or dispiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE WNG Physician/ HRONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events for use as the burlal-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No should be detached g Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 X Yes 3 Probably 4 Unknown 2 🗌 No ERTENSION Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FIBRILLATION autopsy performed? page 2 s 2 N 1 Yes 25. Was case referred to medical the Funeral Director: After this certific npleted filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: Hospital: 1 🗌 Yes 2 💢 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 2 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 2 Accider 5 Pending 2 🗌 No 1 Yes Investigation hours after death Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Daly, Year) 29b. Signature and title of certifier December 02hd mellam.o D41410 2010 MEHTA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUGINDER

Registrar DHMH 17 Rev 7/2009

State

m

SPITA

32. Registrar's Signature

WES

MORTH 31. Date filed (Month, Dav. Year)

3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VOVEMBE! 12:30PM George Edward Zinser Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death saltimare 10W500 if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 1928 Bart Maryland 220-20-2678 81 December 27, Yrs **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County e filed within 72 hours after death with the Maryland tall Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Towson Maryland Baltimore 1 Ves 2 X No 10f. Zip Code 21204 10g. Citizen of What Country? United States of America 10e. Street and Number 1013 Marleigh Circle Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ş 2 No Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. 3 Nidowed 4 ☐ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Polk Audio Logistic Manager Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Grace Murray Louis J. Zinser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Lough Mask Court Unit 302 Timonium, Maryland 19a. Informant's Name/Relationship (Type, Print) Richard C. Mikulski/ representative Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 2, Evans, Further aller place) 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State Forest Hill, Maryland 2010 4 Donation 5 Other (Specify) Chapel-Bel Air Signature Funeral Service License Peaceful Alternatives Funeral and Cremation Certer, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) 24-48 Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying (or as a consequ Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 5 Other (specify) Month Day Vear Pregnant at time of death Yes 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical director Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 2 **X** No 1 Inpatient 2 K ER/Outpatient 3 I DOA filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗆 Pending work?
1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

301 ZOTC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 26. Walter Zientek, Sr. 10:00 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours 96 06/22/1914 Maryland Director 215 22 8652 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director N/A Baltimore 1 🖾 Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1121 Monroe Circle 21225 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Il Hygiene. other than "natural", 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Self Employed Gas Station Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Zientek Agnes Lasek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Zientek Jr. 3810 - 6th Street Baltimore, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 11/29/2010 Holv. Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause op each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or # Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying 0 been signed by the attending physician and should be detached for use as the burial-transit 80 Cause (Disease or iinjury that initiated events resulting in death) Last Dué to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Director: After this certificate ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be 2 No 1 Yes Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOV. 26. 2010

8

Registrar

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12-1-2010 Abbott Α. 6:40p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner 4806 Whitfield Chapel Rd. Prince Lanham George If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeaf) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2√2 F Yrs Director 578-48-4374 9-13-1933 Virginia Usual Residence of Decedent with the Marylend 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Counts 7 is marked other then "naturel", or Iteme 23e or 28e-1 ehow treumatic event, the Medical Examinar must be notified at Md. PG Lanham 1⊠Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4806 Whitfield Chapel Rd. 20706 USA deeth Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene, or her other then "naturel", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 NWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B 2 should be fl and Mentel F Martha Jackson Flax Albert Jackson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Depertment of Heelth and Important: if Item 27 is n eny Injury or other treum once. 17 Riverbend Dr, Marion, N.C. 28752 Janice Macopson-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memo. PK 12-4-10 Landover, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary Inc. 21. Signature of Funeral Service License 411Kennedy St, N.W., Wash, D.C. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Ather scenaliz Pnysician DISCOST SC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discare or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physicien end use as the buriel-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The lew requires that the death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. ate hes been signed by the pege 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 3 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2♥ No certificate 1 ☐ Yes 2 ☐ No Division of Vital : After this certifice a funerel director, Hospital or Attending Physician: 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 T Homicide within 24 hours efter To the Funeral Dire filled in b 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of yeath (Item 23a) (Type, Print) 43 31. Date filed (Month, Day, Year) 0 6 2010 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Sopies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician/ Month Sr. 012010 :30am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4 May Ct ecurity Number Baltimore 8. Date of Birth (Month, Day, 23) 6 Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 - F **Director** 56 54 MD 216-68-7830 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō items 23a or ner must be r Funeral 1414 May Ct. 21231 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status r than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2X No 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 X Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mt. Calvary church 12th grade Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown မ Joseph Alexander Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra 1414 May Ct., Baltimore, Geneva <del>Alexaner-</del>Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/6/2010 On-Site Baltimore, of Funeral Service Licenses 22. Name and Address of Facility
March F/H West 21. Si matu 4300 Wabash Ave Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Coronan Arren Severe disease or condition resulting in death) Medical Due to (or as a consequence Examiner Prostate Cancer Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Urscular Dr sease that initiated events Due\_to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, Hepathos 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Hypertension 25. Was case ref 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖊 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RO72811 12-2-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARREGE 346 Ballo MD 600 N. WOLKST 31. Date filed (Month, Day, Year)
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DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ Virginia Blagmon 10235AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham PG 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours 01-06-1937 579-50-2975 73 Wash . DC Director Usual Residence of Decedent 28a-f shov 10b. County Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Charles MD Waldorf 1 Yes 2 □ No Oe. Street and Number 3004 Gallery Pl. #T3 5 10f. Zip Code 10g. Citizen of What Country? Funeral 20602 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) the Auditor **UPO** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Williams Smith Allen Blagmon Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Paulette Hunter/Daughter 3734 Halloway N. Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Heritage Memorial 12-4-2010 Waldorf, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilitRonald Taylor II FH Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Phumonia Physician/ Unknown Medical Due to (or as a consequence of): Examiner Brust Canun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or impury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No ò Pregnant at time of death Month Day Year detached 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 1 No certificate Yes 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Raintin File D43446 11.23.10. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 TO GOODLOUS PROMISE DR. BOWIE, MD 20720 M.D FARAHIFAR ROIN TAN 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:48 PM Physician/ Burrell Jr. C. December Leroy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Baltimore Hospital Himore 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Hours Min. (Month, Day, Year) 212-26-3255 81 Director MD Usual Residence of Decedent or 28a-f shov 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location notified at with the Maryland Director 1 X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral U.S.A. 21215 3819 Fernhill Ave death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedon. Armed Forces? 1 ☐ Yes 2 🙀 No Examiner Black, White, etc. ō 1 Never Married 2X Married þ If Yes, Give Year or Dates 1 Tes 2 No Specify Specify: Black "natural" 3 Divorced Completed Known Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natuiury or other traumatic event, the Medical jury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Mass Transit Adm. Manager 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Naomi Sands Leroy Burrell Sr. Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3819 Fernhill Ave, Baltimore, Md 21215 Ruby Burrell-Wife 20a. Method of Disposition Department of Healt Important: If item 2 any injury or other timore, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Parallel 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Donation 5 - Other (Specify) 12/11/2010 Woodlawn, Md Memorial Park ure of Funeral Service Licensee 21. Sign March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part I. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death ⊮nysician/ disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine sician and burial-transit Gastrointesluna that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death 9 Unknown page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown or Attending Physician: The law requires 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ✓ No 24a. Was an autopsy performed 2 No After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 🗌 Yes 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice on To the basis of my knowledge, death occurred at the time, date and close to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D066810 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 212115 2435 W BUWEDER WEINTRAUB MD ARON Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 2010 Registrar

DHMH 17 Rev 7/2009

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			For State Registrar	State of Ivi		epartment of Certificate of		ı Mental Hy	ygiene Reg. Ng 2010	37868		
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	Exami		.4a. Facility Name (if not institution, gi 5522 Apperson I			4b. City, Town,	or Location of Dea		4c. County of Dea	ath		
	Funeral Director	_	213-86-7290	Sex 1 □ M 2 X F	e (In yrs. last birthda 49 Yrs	ay) If Under 1 Year Months Days			rth g. B	rthplace (State or Foreign ountry) Maryland		
	Maryland 8a-f show tified at	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Ba	alto.	10c. City, Town or White	Location Marsh	-			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	rith the l 23a or 2 st be no	ralDi	10e. Street and Number	D 1		10f. Zip Code			10g. Citizen of What C			
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene after the many injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fune	5522 Apperson  11. Marital Status  1  Never Married 2 Amarried 3  Widowed 4 Divorced	12. Was Decedent E	ever in U.S.	3. Was Decedent of Hif Yes, specify Cub		Specify Yes or No rto Rican, etc.)				
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Tack.	ould be filed of Mental Hygmarked oth	To Be	17. Father's Name (First, Middle, Last) Charles F. Stadl 19a. Informant's Name/Relationship (	Ler			Dolore	Maiden Surname)				
STILL May	nd 2 sho ealth an m 27 is ier trau		Edward Baker	Spous		ailing Address (Street 22 Appers			er, City or Town, State, Zi [arsh, Md. 2			
~ 5	Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	☐ Removal from State	cemetery, c	sposition (Name of rematory or other place of Faith		Date	20c. Location - City or Balto.Md.			
Baltin	permit Depar Impor any in		21. Signature of Funeral Service Licer	Led I					Funeral Homgham, Md. 2			
000	Ph sician/ Medical Examiner  Physician and Associate and A	Physician/Medical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leads to the immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last	a. Due to (or as a	consequence of):	enter the mode of dyir	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death		
. Box 68760	ss that the death certificate be igned by the attending physic be detached for use as the b	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 1 9 Unknown	Fetal death 3	☐ Ectopic pregnanc	y		23d. Date of de Month	ivery Day Year		
rds. P.O.	e law requires that the state of the state o	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  CHRONIC DESTRUCTIVE PULMONALY PISTASE  1   Yes 2   No 3   Pro									
Reco	n: The law r ficate has b n; page 2 st		25. Was case referred to medical					1 🗆 Yes	prior to or death?	opsy findings available completion of cause of $2 \square No$		
Division of Vital Records.	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day,	Year) injury	ent 3 DOA Other of 28c. Injury work M 1 D	4 □ Nursing F at	lome 5 Resid	ence 6 Other (Special Other) Occurred	fy)		
Divi	To the Hospital or A within 24 hours after To the Funeral Direction properties of the following the	<u>a</u> -	Crieck 2   Medical Exam	sician: To the best of miner: On the basis of exa	(Specify)  y knowledge, death	occured at the time,	n death accurred.	City or Tow	use(s) and manner as sta	ted.		
	To the within 2 To the comple		only one) 3 Certifying Nurse 29b. Signature and title of certifier  P. LEDAK	se Fractioner: To the be	est of my knowledge	29c. License	time, date and pla	ace, and due to the	e cause(s) and manner as:  29d. Date signed (Month)  COMBER	stated. Day, Year)		
10	State		90. Name and address of person who or PLEDAKIS 1.  11. Date filed (Month, Day, Year)	completed cause of dear MD 227	UPA TZ		BAUTIN		MD 2120			
₽√DF	Registra MH 17 Rev 7/200	r	UEC 0 6 201	Denna		Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 303 P Mary Beauchamp Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner alisbur 1:(DW1:CO Poninsula Realism I Marlical Conter If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Country)
Utah 1 ☐ M 2 😿 F Days Hours Min (Month, Day, Director 262-44-0602 88 Feb Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 7722 Stagg Road 21863 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No 14. Race - American Indian, 11. Marital Status Black. White, etc. ö þ 1 Never Married 2 X Married within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 😾 No Specify: white Specify: "natural" 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) nurse healthcare traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) oermit. Page 1 and 2 should be fliv Department of Health and Mental Important: If item 27 is marked of မ Guy Miele Frances Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21863 Willard Beauchamp/spouse 7722 Stagg Road Snow Hill, MD item 2 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If if any injury or o once. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Ronald <sup>22.</sup> Name and Address of Facility State Anatomy Board 655 W. Baltimore Street . Signature ractor 21201 ltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock Immediate Cause (Final Onset and Death Physician/ Myo cardial disease or condition resulting in death) Acute Medical Due to (or as a consequence of) Examiner CongesTINP Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year as been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed 2 No 2 1 🗌 Yes Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 2 1 No မ 1 Yes 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Suicide Investigation **Director:** 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ODE CARROL

D68222

SAlisbury

Md. 2180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State
Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4:45A 2010 Physician/ December Billings Edgar Emery Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Carroll New Windsor 3402 Hawks Hill Road 8. Date of Birth (Month, Day, Year)

Dec 27 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6 Sex Days Hours **Funeral** Months Maryland 1 □XM 2 □ F Yrs 78 Director 217-28-2159 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at death with the Maryland Director 1 Yes 2 X No New Windsor Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21776 Funeral 3402 Hawks Hill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 XMarried þ Page 1 and 2 should be filed within 72 hours after ument of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Specify. 1 Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 Yes, Give Year or Dates. 1951-55 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. Do NOT use retired)

medical photographer, as professor, dept. head 15. Decedent's Education (Specify only highest grade completed) hospital/ College (1-4 or 5+) Elementary/Seconday (0-12) asst. ophthalmology dept 4 11 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Lucy Cooper ၉ Edgar Billings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) New Windsor, MD 21776 3402 Hawks Hill Rd. Myrtle H. Billings/ wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition nr. New Windsor, MD 1 X Burial 2 Cremation 3 Removal from State 12/6/2010 permit. Page
Department of
Important: If
any injury or
once, Winters Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Sign r of Funeral Service License New Windsor, MD 21776 Jarine 310 Church St. Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. 7/23/10+012-27 Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Tectopic pregnancy Live Birth 2 Fetal death Day Year Month in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of peen 24a. Was an autopsy performed death? this certificate has 2 No 1 Yes 2 1 N 26. Place of Death (Check only one) 25. Was case referred to medical Be funeral director, Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 4 10 မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work injury 5 Pending Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 2 Accider
3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

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ame and address of person who completed cause of death (Item 23a) (Type, Print)

32.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

iter Stroot withwister, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 2, 2010 Physician/ 0832 Nicole Lynn Castle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Ctr. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth August 1,1975 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplac (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Maryland Director 214-90-9426 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2X No BelAir Harford Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 728 Grady Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carol L. Holzschuh John O. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 Grady Lane BelAir, Md. 21014 Steve Castle Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12-4-2010 Balto.Md. Bayview 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Internal Between Onstrand Death Brain stem infact Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 Y 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 \(\sigma\) No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 X No Hospital 1 Yes 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) D46052 12 (02/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ponhway, and folio, TVD 31. Date filed (Month, Day, Year) 32. Registraris Signature State DEC 0 6 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 November 10:15 AM Ethel Carey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Future Care Charles Village Baltimore 8. Date of Birth (Month, Day, Sept 2, 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗆 M 2 😾 F Maryland Director 215-22-7767 85 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is anawked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State Director tx☐ Yes 2 ☐ No Baltimore MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21212 USA 4628 York Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Charles Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 Anthony Montaque/grandson 4628 York Road Baltimore,MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ¥ Sther (Specify) in State Ronal d S. Wall 21. Signature State Anatomy Board 655 W. Baltimore Street Director Raltimore, MD 21201 23a. Part 1. Enter the disease, or complications that cause shock or heart failure. List only one cause on each line Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Cevebral VASCULAV ACCIDENT Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) q 🗌 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by dementin 1 Yes 2 No 3 Probably 4 Unknown Completed pertension Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗓 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar

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only one)

Memme

DEC 0 6 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don M-1.

3901 Novih

32. Registrar's Signature

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CHaul

29c. License number

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NovemBer 22.2010

MANO

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c&22 Per FH G910 12/06/10 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 20, 2010 Physician/ Daisy Cole 9:43 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY Washington Adventist Hospital Takoma Park 8. Date of Birth  $JuHy^{(Month, Day, Year)} 1926$ 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral 1 □ M 2 😾 Days Months Hours Min. South Carolina 578-28-4702 84 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No DC none Washington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 5228 4th Street NE #201 20011 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Treasury Dept engraving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollie Stevens Joe Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6000 6th Street NE Washington, DC Shirley Smith/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ⊕ Other (Specify) in state Gate Of Heaven 12/10/2010 Silver Spring,MD Director 3 Name and Address of Board 655 W. Balti J.B. Jenkins FH 2/4/4 LandoverRD Baltimore, 115 21204 W. Baltimore Street LAndover, MD 20785 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ INFARCTION ACUTE MYO CARDIAL Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death
Unknown Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MULTIPLE STROKES 1 Yes 2 No 3 Probably 4 Unknown HYPERTOUSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed' Hospital or Attending Physician: The 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No. 1 Tyes 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending n 24 hours after death.

• Funeral Director: All pleted filled in by the fu 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 pu NOVEMBER 22, 2010 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVONUE, TARROMA PHER, MARYLAND TERRY JODRIE, MD, FACEP 31. Date filed (Month, Day, v, Year) Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year Physician/ William Thomas Cowan Jr. **DECEMBER** .2010 3:33 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Funeral Country) Maryland 1 ₹ M 2 □ F Months Hours Min (Month, Day Or • 26 80 Vrs 214-26-0622 Apr." Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore Lutherville 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a of must be Funeral 9 Nightingale Way Apt. B-4 21093 USA ral", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify "natural", Completed 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working If Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Cowan Transportation CEOpermit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Thomas Cowan Elsie Lillian Kalter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 S. Clayton Street; Wilmington, DE 19805 William T. Cowan III son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State Hilltop Service Corp 12/11/2010 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 1050 York Road 22. Name and Address of Facility 21. Signature of Ruck Towson Funeral Home. INc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final 24 HOURS Ph\_sician/ disease or condition resulting in death) INTESTINAL ILEUS AND HYPOTENSION Medical Due to (or as a consequence of) Examiner 24 HOURS SIGMOID COLON OBSTRUCTION Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for uses as the burlan-transit 24 HOURS ACUTE PELVIC CAVITY BLEED that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) 2 No cate has been signed by the a page 2 should be detached it g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes Yes 2 🗆 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one d title of der Signatu 29d. Date signed (Month, Day, Year) PATHOLOGIST D34543 DECEMBER 4, 2010

Registrar
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State

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DRIVE BALTIMORE MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's

Maryland 21215-0036 Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#30 Per DVR G910 12/06/10 Jh
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November Day 23 20010 Irene Denver 1406 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital at Easton talbot Easton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb 15, 1 Birthplace (State or Foreign Country)
 Maryland Funeral Days 1 □ M 2 🗓 F Months Hours 212-40-8127 Director Vrs 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown with injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 175 Seagull Drive 21122 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 ☐ Married If Yes Give 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frank Denver Alvina Yoskoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Ireland/daughter 175 Seagull Drive Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Euneral Service Rona La Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ myocardia Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month signed by the a d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page After this certificate I funeral director, pag-1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No injury 1 Natural 5 Pending Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) romes Walsh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Walsh MD Primary Care 115 Salitt DR. Stevenson, MD 21666 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 5:35 PM Movember Kenneth Alden Darner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 14510 Water Company Road Cascade 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. g, Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 1 🛛 M 2 🗆 F Months Days Hours Min Director Maryland 217-34-2323 74 Nov. Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Maryland Washington Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14510 Water Company Rd. 21719 U.S.A. "natural", or item edical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Year or Dates. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) truck 11 tile setter/ driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Alden Darner Helen Lee Swartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Darner/ wife 14510 Water Company Rd. Cascade, MD 21719 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Luth. Cem. 12/2/2010 Jefferson, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home attaine ( 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. wetastatic Square to (or as a consequence of uamous cell concer of lun disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or se a nonsecuence of): If any, leading to immediate cause, Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 29,2010 Cynthea Kuterer - Sands no D47451 747 Nosthern Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice of Washington County Cynthia Kuttner Sands ND Haperstown Maryland 217+2 31. Date filed (Month 37. Registrar's Signat State Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Otate of W	ai yiaii		tificate of				Reg. No		07077
			Decedent's Name (First	t, Middle, Last)							2. Date of Dea	ath	2010	3. Time of Death
	Physicia Medic		RAELLA		DANIL	LER					DECEMB:	ER Ĉ	71, 2010	3:10 A M
and of	Examin		4a. Facility Name (if not in	-				4b. City, Town,				4c	. County of Death	
- Company			8909 REIS'  5. Social Security Number			o (In ure la	ast birthday)	BALT]		ler 24 Hrs.	8. Date of Birt	th.	BALTIMOR	Liplace (State or Foreign
	Funeral Director		214-24-894 Usual Residence of Dece	2 1 🗆	M 2 F 7. Ag	83	Yrs.	Months Days Hours Min. 11/22/11927						ntn/l
	/land f show ed at	tor		County			y, Town or Lo							10d. Inside City Limits
	e Mar 28a- notifi	Director	MD 10e. Street and Number	BALTIMO	ORE		BALTIM	ORE 10f. Zip Code						1 Yes 2 No
	with the	Funeral I	8909 REIST	ERSTOWN	ROAD			2120				10g. Cr	tizen of What Cou USA	intry?
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 3 汉 Widowed 4 □ I	2 Married	2. Was Decedent E Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rlack M						14. Race - Ameri Black, White, Specify:	
2-0	hour hatur dical	olete		Decedent's Edu nly highest grade	cation			lent's Usual Occi		act of work	na l	16b. K	(ind of Business Ir	ndustry
21215-0036	led within 72 Hygiene. <b>other than '</b> ent, the Me	Completed	Elementary/Seconday		College (1-4 or 5	5+)	life. DO	NOT use retired		OST OF WORK	ng	M	1ANUFACTI	JRING
Maryland	ntal Hyged intal Hyged ced others:	To Be	17. Father's Name (First, i	Middle, Last)		COLD	CTEIN		i	other's Nam	e (First, Middle,	Maiden	Surname)	TUCKER
Ž	should be file and Mental F is marked o raumatic eve	Ì	BENJAMIN  19a. Informant's Name/R	Relationship (Type	e, Print)	GOLD	STEIN	a Address (Stree			al Route Numbe	r City or	Town, State, Zip	
	d 2 sh alth a 1 27 is er trau		ANITA GOR	DON/DAU	GHTER			-					CITY, MI	
ore,	e 1 and of Heal If item		20a. Method of Disposition		emoval from State	20b. P	lace of Dispo	sition (Name of	PCRI-		Date	20c. L	ocation - City or T	own, State
Baltimore,	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other trooper.		4 Donation 5 D	Other (Specify)	4	C		MUNAH A EMETERY		1	3/2010		ALTIMORE	
Bal	21. Signature of Juneral Service Licensee							. Name and Addi					& BROS.	
	Physician Medical		23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	sease, or complic ire. List only one a.	cause on each line	enti	a Ala	the mode of dy			or respiratory arr	rest,		Approximate Interval Between Onset and Death
sole,	Examiner		Due to (or as a consequence of).											
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury											
	ate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last	C.	Due to (or as	a consequ	ence of):	_						
8760	ate be physic the bu	<b>Nedical</b>		d d										
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 424 hours after death.  Funeral Director, After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M										23d. Date of deliv Month	rery Day Year	
P.O.	that the ned by detact		Part II. Other significant	conditions cont	ributing to death b	ut not res	ulting in the u	nderlying cause	given in Pa	art I.	23e. Did to	obacco u	use contribute to 1	he cause of death?
ds,	v requires the been signed should be a	ted									1 🗆 '	Yes 2	□ No 3 □ Pro	bably 4 🖶 Unknown
of Vital Records,	The law re ate has be page 2 sh	Completed by										osy rmed?	prior to co death?	opsy findings available ompletion of cause of
E B	iician: The certificate rector, pag	o l	25. Was case referred to	medical				26.	Place of D	eath (Check		2 <b>N</b>	o 1 Yes	2 12-1 No
Vita	ysician: ils certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Ho	spital: 1 🔲 Inpati	ent 2 🗆	ER/Outpatien	t 3 DOA	her:	Nursing Ho	me 5 Resid	dence 6	S Other (Specif	y)
on of	ttending PP death. ctor: After th y the funeral	Certificate:	2 Accident	Pending Investigation	28a. Date of inju (Month, Day	ry v, Year)	28b. Time of injury		uryat rk? ∐Yes 2	_	28d. Describe h	ow injur	y occurred	
Division	al or Attences after death		3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injubulding, etc			eet, factory, office			28f. Location (S City or Tow		d Number or Rura )	l Route Number,
building, etc. (Specify)  City or Town, State)  State  Page 1										e, and due to the ca	ause(s) and manner stated.			
	To the To the Congression	-	29b. Signa ure and title o	f certifier				29c. Licer	se numbe	r		29d. Da	te signed (Month.	Dav. Year)
			Joseph	Back	MD			D00	61199	7		Dec	. L. 20	10
			30. Name and address of	person who cor	ppleted cause of d	eath (Item	23a) (Type, P	rint) Suite	4105	- , 700	usun 1	40	21204	
			31. Date filed (Month_Day	Yearla a s	1/22 Pagistre	via Cia de	Uro							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 3. John Edward Dolan 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore/Washington Medical Center Glen Burnie Anne Arundel Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 □ F Days Hours Octoger 9 Director 212-36-7577 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 No Maryland Harford Forest Hill 10e. Street and Number 10g. Citizen of What Country? 1709 Cannongate Road 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Funeral Director Funeral Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Dolan, Sr. Charlotte A. McGuire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janet C.Croucher (Daughter) 1709 Cannongate Road Forest Hill, Md. 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gdms. 12/7/2010 Timonium Maryland 21. Signature of Four ray ervice Li er see 22. Name and Address of Facility Md. 21204 Towson, Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Arterioscleratic disease or condition resulting in death) Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed perlipidemia Cause (Disease or linjury that initiated events resulting in death) Last Due to or as a consequence of signed by the attending physician and be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕽 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has certificate ha irector, page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: မ 1 Inpatient 2 KER/Outpatient 3 IDOA this ( 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

OHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month Park

DEC 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Phyllis May Fox aka Phyllis Mae Fox 2010 December 12:45 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Hebrew Home 8. Date of Birth (Month, Day, Dec • 29 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Year 19<u>25</u> 1 🗆 M XX F Days Hours Maryland Dec. Director 220-20-1893 84 Usual Residence of Decedent or 28a-f show notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Tes 2XXNo Baltimore Owings Mills Maryland 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? United States "natural", or items 23a or idical Examiner must be i Funeral hours after death with 21117 3017 Walnut Avenue of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3XXWidowed 4 Divorced Completed Year or Dates al Hygiene. d other than "nature event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 12th Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H Helen Evelyn Worrell Robert Anthony Shillenn and 2 should be Health and Mer tem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10519 Amity Street, Lorton, Virginia 22079 Dennis G. Hudgins (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Dec Date 6, permit. Page 1 and Department of I Important: If its any injury or of AII Faiths Crematory & Chape1 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Manchester, Maryland 2010 Signature of Fune allowing the Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Cause (Final Physician, a <u>Renal Failure</u> disease or condition Medical resulting in death) Due to (or as a consequence of): . Examiner Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that the death certificate be executed Sepsis and resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death signed by the a d be detached f g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disēase 2 No 3 Probably 4 Unknown Records, been sig Completed 24b. Were autopsy findings available 24a Was an Chronic Renal Insufficiency ate has t autopsy performed? Yes 2 No prior to completion of cause of certificate 1 Yes 2 No 1 Yes o the Hospital or Attending Physician: Thin 24 hours after death.

o the Funeral Director: After this certifical or projected filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4XXNursing Home 5 Residence 6 Other (Specify) Hospital XX<sub>No</sub> 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical XX certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hos To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c License number 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) DO02 JE84 121 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road, Rockville, Maryland 20852 Damien J. Doyle, M.D.,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 6 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #11 Per ANA BD G910 12/17/10 JH

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year John W. Fedd III /Medical November 18. 2010 3:45 PM 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3939 Roland Avenue #422 Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☑ M 2 ☐ F Min 218-28-8948 Director Feb 17. 1933 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the the disclosi Examiner must be notified at Director MD 1√2 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 Roland Avenue 21211 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 XXidowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 12 salesman hospitality permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, It 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Fedd Jr Pearl Dalton ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Morgan/daughter 605 Yale Avenue Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) ROTATION Service Lice Starte and Adversory Farbard 655 W. Baltimore Street Director 21201 Baltimore, MD a. Part in Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERY DISEASE COLONARY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine bue to (brids a consequence of): and law requires that the death certificate be execu burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the detached i 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of dause of death? 24a. Was an autopsy performed certificate 2 140 1 □ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 1∐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Nesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Whatural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signature a title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51715 -010 K. GUATI MA

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed

Jacks-

FALLS

ROMO

BATIMORE

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

3730

32. Registrar's Signature

A71,

<sup>year)</sup> 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Day DOLORES A. FOARD 2010 8:30 A.™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS TIMONIUM BALTIMORE Social Security Numbe 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □**X**F Months Days Hours 91 4/25/1919 Director 219-28-9041 MARYLAND Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD N/A BALTIMORE CITY 1 🕅 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2209 PELHAM AVENUE 21213 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates. 3 □XWidowed 4 □ Divorced Specify: WHITE injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 8TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOUIS H. WELLEIN MARY A. UNKELBACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERARD J. FOARD/SON 5426 JERSEYBELLE COURT ELLICOTT CITY, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State DULANEY VALLEY MEM. 4 ☐ Donation 5 ☐ Other (Specify) 12/9/2010 COCKEYSVILLE, MD Signature of Euneral Service Licensee MOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pavo Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi): use as the burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🕱 No Pregnant at time of death Day Year 1 Yes 2 9 Unknown been signed by the should be detached PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy Hospital or Attending Physician: The 1 Tes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier Date signed (Month, Day, Year) M SOLD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DÜLANEY VALLEY ROAD ERNESTINE WRIGHT, M.D. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Regis trar's Signature State DEC 0 Registrar

DHMH 17 Rev 7/2009

DECEMBER

DOLORES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2010 xiemper /Medical 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 09/08/1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 XF Hours MARYLAND 217-20-0013 84 Yrs. **Director** Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Examiner must be notified at 1 X es 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò 115 N. KENWOOD AVENUE 21224 U.S.A. Funeral Items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify. 2 3 X Widowed 4 ☐ Divorced Specify. WHITE "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) OWNER BEAUTY SHOP 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH MARY TORRE FERICE မ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health at
Important: If Item 27 is
any injury or other trau 9570 BOLTON ESTATES RD., MILLINGTON, TN 38053 JOHN GLOWACKI/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY 12/3/2010 BALTIMORE, MARYLAND 21. Signature of Fun Vice Licensee 22. Name and Address of Eacility
LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Brain disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed -trar Due to (or as a consequence of) physician ar as the burial-t Box 68760 Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 mont 4 Pregnant at time of death 9 Unknown Month Day Year 5 Other (specify) 2 No P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Id be de þ of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 吕 shou 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 2 1 No 1 Yes 2 No certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Physician: 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 Thpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month Day Year) Division or Attending 1 Natural 5 Pending 1/2010 Threat jumped Panushou St. Location (Steet an Number or Rural Route Number, 2 Accident
3 Suicide investigation 8 YYAM 1 Yes Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. determined filled in by 4 Homicide esidence 21224 Lewwood Are 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signat 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 6 2010

ear) 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37883 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2/2/2010 C. Marie Goodwin 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hidden Treasures Assisted Living Carrol1 Westminster 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 XF Months Days Hours Min. 471871913 Director MD 217-46-2243 Usual Residence of Decedent 28a-f show ä 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1600 Hoods Mill Rd 21797 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3XXWidowed 4 ☐ Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Her Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked o any injury or other traumatic eve once. ဂ္ဂ Oliver Fleming Elsie Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Zepp/Son-In-Law 1201 W. Old Liberty Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State onation 5 Other (Specify) Ebenezer UMC Cemetery 12/7/2010 Winfield, MD of Funeral Service Licens 22 Burrier Outer Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1 Enter the disease, or complication shoc, or heart failure. List only one caus Approximate Interval Between Onset and Death media Cause (Final Physician/ NTRICULTA r condition Medical Due to (or as a consequence of): Examiner EROSCLEROTIC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Dav 5 Other (specify) Year Pregnant at time of death be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No 6 Other (Specify) ASSILE & 욘 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd fitle of certifier 29d. Date signed (Month, Day, Year) ngowall DOC 18 200 12-03-2010

DHMH 17 Rev 7/2009

State Registrar 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chitrachedy Naganza, Mb, 700 A Poole Rd, Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 37884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year James 6:50pm homas Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death West wins 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 🗆 F Hours (Month, Day, Director 217-38-2147 70 New Usual Residence of Deceden permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pine. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Carrol1 Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Timber Ridge Drive 21157 **IISA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Priysician/ Medical

Examiner

signed by the attending physician and a betached for use as the burial-tran within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

۲	Oliver Clinton Grammer			Edna G	arner				
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address	s (Street and Num	ber or Rural F	Route Numb	ner City o	r Town State 7	Zin Cada)	
	Margiana Senseny/sister	833 Teet					17340	up Code)	
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	Place of Disposition (Nar emetery, crematory or c	ne of	Da		_	ocation - City o	or Town, State	
	21. Signal of Funeral Sept e Licen of Director		Affarenty	™oard 21201		. Ba	1timore	Street	
	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of the consequence of the cause of th	n. Do not enter the mod	e of dying, such a	is cardiac or r	respiratory a	arrest,		Approximate Interval Between Onset and Death	
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to (or as a consequence of the conseque								
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of de Month							
ted by P	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying o	cause given in Pari	t I.				o the cause of death? Probably 4 Unknown	
	OF Western day of				24a. Was auto perfo 1  Yes	psy ormed?_	prior to death?	stopsy findings available completion of cause of	
m ,	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check on	nly one)				
Medical Certificate: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident Investigation 3 Suicide 6 Could not be	injury M	Bc. Injury at work? 1  Yes 2	28d		sidence 6 X Other (Specify) Dave Hex 37			
al Cer	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)				City or Tov	vn, State)		ral Route Number,	
	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowled only one) 3 Certifying Nurse Practioner: To the best of my knowled only one) 5 Certifying Nurse Practioner: To the best of my knowled only one onl								
2	29b. Signature and title of certifier		License number				e signed (Month		
	Molert X Keie mo Pin		D0069	(557)			11/22	3/10	

ST WESTMINSTER, NO. 21157

State Registrar

Day,

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year George Wetherbee Helfrich 6:00P M Medical 2010 November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1XXM 2 □ F Months July 9, 1935 Hours Maryland Director 75 Yrs. 215-30-8126 Usual Residence of Decedent show 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1XX Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Completed by Funeral 2516 Maryland Avenue 21218 America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1XXYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4XXDivorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Relator Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Helfrich Eleanor Foote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilhelm C. Helfrich (Son) 15433 Falls Road, Sparks, Maryland 21152 Date 3, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial ②XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Faiths Crematory
& Chapel Dec. 2010 Manchester, Maryland 21 Signature of Fun a la joe Licer 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. may <u>3296 Charmil Drive, Manchester, Marvland 21102</u> Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Physician/ Due to (or as a consequence of): ase or condition cancer / Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performed 1 🗆 Yes 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Sulcide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 00043489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson MD 21204

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

0

James Michael	Higa	ins Please Type or Print in Black Indelible Ink. Ensure All Copie  Output  Department of Health and Mental H			17000
James Michael		1- For State Of Maryland / Department of Health and Mental H		2010	37886
Physici		Registrar  1. Decedent's Name (First, Middle,Last)	Reg. N 2. Date of Death		3. Time of Death
Medical Exam		James Michael Higgins	Month Day December 4,	y Year 2010	0735 hrs
(		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death	
		12576 Indian Hill Drive Sykesville		Howard	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min		M/DD/YYYY) 9. Birt Foreig	n
Director		218-54-2271 XXM 2 F 51 Yrs.	Nov. 9,	1959 Cou	intry)Maryland
any		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County           10c. City, Town or Location			10d. Inside City Limits
1 10w ai					1 Yes 2XX No
nylan <b>sa-fsi</b> at ong	턍	Maryland Howard Sykesville  10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Cour	try?
he Ma i or 23	Director	12576 Indian Hill Drive 21784		Jnited Sta of America	
with t	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	
death r iten	51	1 Never Married 2XX Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		_!	ite
hours natur Exam	I	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of volume for the during most of working life. DO NOT use retired to the during most of working life.		b. Kind of Business/Ir	ndustry
36 in 72 han "	mpletec	Elementary/Secondary (0-12) College (1-4 or 5+)		Doofing	~
-00 d with gene ther t	Com	2 Contractor  17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, Maide	Roofing en Surname)	
215 ce file nal Hy ked o	Be	James Robert Higgins Barba	ra Helen E	Poor	
21 ould I d Mer s mar	ျှ	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or I	Rural Route Number,	City or Town, State,	Zip Code)
MD d 2 sh lth an n 27 i		Lynette Reber Higgins (Wife)   12576 Indian Hill Dri			
ore, s 1 an of Hea		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery,  1 Burial 2 XX Cremation 3 Removal from State All Falths Crematory	Date 20	c. Location - City or	Iown, State
imo Page nent c		4 Donation 5 Other Specify: & Chapel	2010 M	anchester	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Finance Licensee 22. Name and Address of Facility E.C.			
	-1	3a. For I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac of	Road, Ow	ings Mills	Approximate Interval
Physician		allure. List only one cause on each line.  Hypertensive atherosclerotic card			Between Onset and Death
≟xaminer		or condition resulting in death)  Due to (or as a consequence of):	Tovasculai	uisease	Doder
		Sequentially list conditions, b.			
	Je.	if any, leading to immediate Due to (or as a consequence of):			
_	Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):			
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760 icate t	₩.	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
r 68 certif ending use as	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnated by the past 12 months?  4 Pregnant at time of death 5 Other (Specify)	ancy	Month D	ay Year
BOy death he atte	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown			
Vital Records, P.O. Box 68760, hystrian: The law requires that the death certificate be executed this certificate has been signed by the attending physician and I director, page 2 should be detached for use as the burial - transit		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to t	
S, P tires th signe d be d	d be				ably 4 V Unknown
ord; w requisible been shout	Completed		24a. Was an autopsy	prior to co	opsy findings available on completion of cause of
Cec(The latate had age 2	E O		performed  Yes 2	? death? No 1 ✓ Ye	s 2 No
al Fi	ادہ	25. Was case referred to medical examiner?	only one)		
Vit hysica this c	To B	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursir	-	idence 6 🗸 Other	Scene
Jing Pl	• •	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 X Natural 5 Pending	28d. Describe how i	injury occurred	
Sior Attend death ceath cctor:	catio	A Natural 5 Pending Investigation   1 Yes 2 No Investigation   28e. Place of Injury - At home, farm, street, factory, office building, etc.	20t Leasting (Street	t and Number of Dur	al Route Number, City
Division of all or a safter of all Direct of all of the control of	Certification	Suicide Could not be determined (Specify)	or Town, State)		al Notice Number, Oily
Lospit Hospit Hour Tuners		29a. Certifier   Certifier   Dhysisian To the best of my knowledge death accurred at the time date and place and	due to the cause(s)	and manner as state	d.
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
F 2 2 0	Ne Ne	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mon	th, Day, Year)
		O.C.M.E.	D	ecember 5, 201	0
HUS		30. Name and address of person who completed cause of death (Item 23a)	D 04531		
Direc		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M	21201 ט		
S	tate	31. Date filed (Month, Day Year) 32. Registrar's Lignature			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical acility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner MORE 9. Birthplace (State or Fore) If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1√ M 2□ F Months Hours Min. Director 578**-**52-1022 Oct 29, 1940 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatte event, the Medical Examiner must be notitied at 10a, State 10c. City, Town or Location "natural", or items 23a or 28a-f show adical Examiner must be notified at Director Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6405 Elm Way 20735 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Manor Nursing Home 2095 Rockrose Avenue Baltimore, MD permit. Pages 1 al Department of Hea Important; if Item any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 87. Wade rector Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. 23a. Part Immediate Cause (Final disease or condition resulting in death) Physician Halmating /Medical Due to (or as a consequence of): Examiner Obetructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed 808 hate and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical 0 IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a. Was an autopsy certificate perform 20 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 NO 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director:

23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 | Probably 4 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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N. ENTAW

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3. Time of Death

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10d. Inside City Limits

1 ☐ Yes 2 ☐ No

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unk

Approximate Interval Between Onset and Death

Day

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Year

State Registrar

Medical

SHOA113

31. Date filed (Month, Day, Year)

DEC 0 6 2010

DHMH 17 Rev 1/2001

e Funeral I

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**ORIGINAL** 

MD

MD

.32. Registrar's Signature

821

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IMDI EATI

,	
10-08684	
Tanya Holster	

Please Type or Print in Black Indelible Ink. Ensur	re All Copies Are Legible.	0.7000
State of Maryland / Department of Health ar	nd Mental Hygiene 2010	37888
Certificate of Death	Reg. No.	
Pallome (First Asiddle 1 oct)	2 Date of Death	2 Time of Death

		1- For State Registrar				Certific	ate of	Death				R	eg. No	).			
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Medical Exami	ner	Tanya Hols	ter								- 1	Month Novembe	r 12,	2010 Yea	·	1620 h	rs
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5-00 led witi Hygien other the Mo	ह	17. Father's Name (First, Middl	e, Last)					· <del>unk</del>	18	8.Mother	s Name (	First, Middle,	Maiden Surname)				
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_		30. Name and address of person	on who o	empleted on	ise of death	(Item 23a)	-										
		Russell Alexander M		Assistant I			111	Penn Str	eet.	Baltimo	ore, MD	21201					
S	tate				egistrar's S	ignature			, -		,		-			_	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37889 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ANDRA HOUSTON MARCUS 000 1 Q Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Nov 26, 2010 6. Sex 9. Birthplace (State or Foreign **Funeral** Min. 50 1 🕅 M 2 🗆 F Months Days Hours Maryland Director infant Nov Usual Residence of Decedent 28a-f shov 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No MD Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 20613 USA 15509 Wylie Road items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ō þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced Specify black the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant 2 should be filed w h and Mental Hygir 7 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ige 1 and 2 should be into of Health and Ments t: If item 27 is marked or other traumatic e Tiye Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Medical Center 22 S. Greene Street Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 🛛 Other (Specify) in state State Andrem Factor 655 W. Baltimore Street Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part shock Approximate Interval Between Onset and Death Immediate Cause (Final Physician rematurit disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death the g Unknown g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed 1 🗌 Yes 1 Yes 2 No 2 No To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 2 2 No 1 Inpatient 2 . ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 29d. Date signed (Month, Day, Year)

State Registrar Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIGO

MID

22

32. Registrar's Signatur

1184

Baltimore

MD

21201

St

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20a-c, State FH Maryland 2 Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 3 Day 12 Month Physician/ 2010 Year Ronald W. Howell Sr. 9:07 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City 1321 Church St. Baltimore . Age (In yrs. last birthday)
50 Yrs. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** Min. Months Days Hours 6/1977 1960 1 🕅 M 2 🗆 F 220-66-5472 MD Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State the Medical Examiner must be notified at MD 1X Yes 2 No Baltimore City Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 1321 Church Street 21226 USA should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white ted 3 Widowed 4 Divorced Complet Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Labor Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H Robert Howell Helen Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 s tment of Health a item 27 Teresa M. Howell/wife 1321 Church St. Baltimore MD 21226 20c. Location - City or Town, Sta Catonsville, MD Crownsville MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of h Important: If ite Me errorer Creating of place) Removal from State 12/9/2010 eterans Cemetery <del>Crownsville</del> 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Signature of Funeral Service any M01364 421 Crain Hwy SE Glen Burnie MD 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate shock, or heart failure. List only one cause ach line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last **Medical** Box 68760 the attending p IF FEMALE Physician/ 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 L Yes 2 L 9 Unknown g Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A M Investigation Accident within 24 hours after dear To the Funeral Director completed filled in by the 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

DEC 0 6 2010

32. registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day John Henry Harden Medical December 2010 6:08 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Baltimore Towson 8. Date of Birth (Month, Day, Year) 9/19/1956 If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours Director 219-66-9083 Georgia or 28a-f shov within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕅 No Maryland Baltimore Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1103 Mace Avenue 21221 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Electronics Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Thornton Harden Leila Blanche Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Sister) Susan Eileen Shellenberger 613 Third Street Rehoboth Beach, Delaware 19971 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 $\overline{\mathbb{X}}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith <u>Overlea, Maryland</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ HEART ONGESTIVE disease or condition CONTHS Medical resulting in death) Due to (or as a consequence of) Examiner ARDIOMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RONAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b HRONIC OBSTRUCTIVE PULMONARY DISONSE Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate HYPORTENSION Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗖 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certific

ICHA 31. Date filed (Mor

and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) DECOMBAR 4

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible

Eric Hill			rtment of Health and Mental F							
	1- For State Registrar	Cen	tificate of Death	Reg. No.	110 3/892					
Physician/ Medical Examiner	Decedent's Name (First, Midd	le,Last),		2. Date of Death  Month Day Ye  December 1, 2010	3. Time of Death 2300 hrs					
	4a. Facility Name (if not institution University Hospital	n, give street and number)	4b. City, Town, or Location of Deal Baltimore	th 4c. County	of Death					
Funeral Director	5. Social Security Number	6. Sex 7. Age (In yrs. Ia	t birthday)  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.  Yrs.  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.  Min.  Min.  Min.  Min.							
any	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits					
the Maryland a or 28a-f show tiffed at once.	10e. Street and Number	Bo	Utinore 10f. Zip Code	10g. Citizen of W	1 Yes 2 No					
ith the M 123a or 2 2 notified	3613 Pex	mere Poach  12. Was Decedent Ever in U.S.	3. 13. Was Decedent of Hispanic Origin?	Specify Ves or No. 114 Page	se - American Indian, Black,					
imore, MD 21215-0036  Seges I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Take: If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Exminer must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2 M	A 1 5 0	If Yes, specify Cuban, Mexican, Puert		Teles etc.					
5 72 hours aft matural? al Ex mine	15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest grade completed)  College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re	tired)	susiness/Industry					
215-0036 be filed within 72 hour ntal Hygiene. ked other than "mati ent, the Medical Exer Be Completed	17. Father's Name (First, Middle,	2 years	Maintanance 18. Mother's Nam	May BWE  Be (First, Middle, Maiden Surnam	I-Airport					
Baltimore, MD 21215-00 sernit. Pages I and 2 should be filed wit Department of Health and Mental Hygien inportant: If item 27 is marked other njury or other traumatic event, the M To Be Com	James L 19a Informant's Name/Relations	Dright	19b. Mailing Address (Street and umber or	N Wink lea						
mn 212.  and 2 should be lealth and Menta ten 27 is marke traumatic even traumatic be Do	Bonita 11	Hill (WiFe)	136/3 Rexmere	Rd. Bato,	MD 2/2/8 - City or Town, State					
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum	1 Burial 2 Cremation 4 Donation 5 Other St	3 Removal from State	rematory or other place)  On Memorial Park, 12	18/2010 Bal-	b.MD					
Balti permit. Departu Import	21. Signature of Funeral Pervice	1101707	2. Name and Adviess of Factivity	reeve Fin	peral Services					
Physician "Medical	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. Pontine	Do not enter the mode of dying such as cardiac Hemorrhage due to Hype	or respiratory arrest, shock, or he	eart Approximate Interval Between Onset and Death					
miner	or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequence of)								
ted nsit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of)  c.  Due to (or as a consequence of)		1						
oe executed cician and arrisit and arrisit dical Ex	wents resulting in death) Last  X UNPENDED	d	per me g913 3-8-11 vt		^ ^					
60, ate be e hysicia e buria	IF FEMALE:	23c. If yes, outcome of pregn	<del>-</del>	23d. Date of	of delivery					
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be rs after death.  3 Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burner diffication: To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unl	1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregr		Day Year					
P.O. Es that the cape of detached by the by Phy	Part II. Other significant condit	ions contributing to death but not re-	sulting in the underlying cause given in Part I.		ribute to the cause of death?					
Division of Vital Records, P.O. Box not the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for usedical Certification: To Be Completed by Physic				24a. Was an 24b. autopsy	Were autopsy findings available prior to completion of cause of					
Rec: The lift rate hit page Com					death? 1 Yes 2 No					
/ital	25. Was case referred to medica examiner?  1 V Yes 2 No	Heesitel.	26.Place of Death (Check ER/Outpatient 3 DOA Other Nurs	ing Home 5 Residence 6	Other:					
nn of Vi nding Physi th. : After this e funeral di ion: To	27. Manner of Death  1 X Natural 5 Pend	(Month, Day,Year)	28b. Time of Injury   28c. Injury at Work?	28d. Describe how injury occur	_					
Division o Within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ledical Certification:	2 Accident Inves 3 Suicide 6 Coul	stigation 28e. Place of Injury - At hor	me, farm, street, factory, office building, etc.	28f. Location (Street and Numl or Town, State)	ber or Rural Route Number, City					
ig ne poi	29a. Certifier (Check only) 1 Certifying Pl	nysician: To the best of my knowledge	e, death occurred at the time, date and place, an							
To the Ho within 24 To the Fu completel	29b. Signature and title of certifie	and manner stated.	d/or investigation, in my opinion, death occurred  29c. License number		ned (Month, Day, Year)					
	m	MAN	O.C.M.E.	December	r 2, 2010					
	Russell Alexander MD		· ·	1D 21201						
State Registrar	31. Date filed (Month, Day)	32. Registrar's Signatur	face							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2010 Physician/ Mary Jones Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore House of TLC If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 5. Social Security Numb 579-24-9914 **Funeral** 1 🗆 M 2 💢 F Days Hours Min 12-29-1919 Director 90 North Carolina Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director PG Laurel 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6907 Redmiles Rd. 20707 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 9 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: Black 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Hartsfield Lucy J. Egerston J. 19a. Informant's Name/Relationship (Type, Print)
Jacqueline Jones/Daughter—in law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $6907\ Redmiles\ Rd.\ Laurel,\ MD\ 20707$ Department of Health a Important: If item 27 is any injury or other tran 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial 12-4-2010 Landover, MD Donation 5 Other (Specify) 2). Signature of uneral Se 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Physician/ ADVANCE D disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner Dusito (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Day Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 I onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Tes 2 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner's Hospital Other: 1 🗌 Yes 2 146 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier D 51715 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M5V411 FAUS

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOV & mb 10150 MM Johnita A. Johnson Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Baltimore Washington Med Ctr Glen Burnie PHONING 5. Social Security Number If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Min (Month, Day, 1 M 2 X F Director 104-12-6957 90 1920 May Mary Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD Anne Arundel 1 Tes 2x No Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 538 Queen Ann Avenue 21113 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>administrator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grover Felix johnson Ida Eve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dorothea Kinslow/friend 1318 Huntover Drive Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Eureral Service Licensee Rona La S W Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pau 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Come (Fi Come (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been siç ; page 2 should b Completed 1 Tes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 1 Yes 2° No Certificate: To ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 - Pending 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nupre-Prantioner: To the best of my knowledge; de 29b. Signature and title of certifier Date signed (Month, Day, Year) 2010 30. Name and addre ss of person who completed cause of death (Item 23a) (Type, Print) 0197 WUSU L 81. Date filed (Month, Day, Year) 32. Registrar's Signature State arket Registrar

DHMH 17 Rev 7/2009

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician**  $P^{M}$ Francis Julius November 16 2010 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 705 Compass Road Middle River Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🛛 F Months Days 215-24-4635 79 Director Aug 20, 1931 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2√☐ No Director MD Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 705 Compass Road 21220 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ∏ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ģ Specify: white 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the MMI once. College (1-4or 5+) Elementary/Secondary (0-12) senior citizens help secretary unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4220 Babylon Road Taneytown, MD 21787 Lloyd Sharp/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Sur eral Survices TareandAddressonFyciiiBoard 655 W. Baltimore Street Wade Director Baltimore, MD 21201 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause Final disease or condition resulting in death)

a. Characteristics Characteristics Char Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ZYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EN-Zene A KENVE Bellimore Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19asb Per TNF G910 12/21/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year ZOID Rose Kutze( Month 5:45 PM December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 Hours 11/29/1918 Director 053-12-9306 92 POLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified \*\* once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6210 PARK HEIGHTS AVENUE, #802 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Yes 2 XNo If Yes, Give Year or Dates. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐X No Specify: 3 Divorced Specify. Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) PROPRIETOR OFFICE SUPPLIES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH **GOLDBERG** BLUMA ROSENZWEIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

443B, NEW YORK, NY 16 NEIL GOLDBERG/NEPHEW NEW YORK, NY 10019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) BETH TFILOH CONGR. 12/03/2010 BALTIMORE, MD 22. Name and Address of Facility Sign sure o Funeral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage CVA Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) as the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 No the Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 □ Nursing Home 5 □ Residence 6 1 Other (Specify) 2 🗷 No Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier ☑ certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number nskajapahremin 00057465 12/2/10 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

N - S - RAJAPA KFC - M D - Z 8 35 5 m + D AV - S Baltimore, MD. 21209. 2835 5min AV-5-203 -

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene U | U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Daisy Darrell Lumley М 2010 Medical 3:28p. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5800 Hamlim Ave Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 84 215-80-4896 Jamaica Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyaminar must be a constant. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore MD NA 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5800 Hamlim Ave 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3√ Widowed 4 □ Divorced Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Self Employed 3rd Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Iona Satchell Bonito McKay 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a Whittingham Burke 5800 Hamlin Ave, Baltimore, Md 21215 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Druid Ridge 12/11/2010 Pikesville, Md 21. Si 22. Name and Address of Facility
March F/H West
4300 Wabash Ave of Funeral Service Licen Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Due to (or as a consequence of): Physician/ one de40 Medical resulting in death) Examiner weeks Gaque Itially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as on the Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performe 2 No 1 Yes 1 ☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only on 29b. Signature and til 29c. License number 29d. Date signed (Month, Day, Year) AttendiNE D17/18 Dec 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3512 Newland Rd 21218 SCHWARTZ MO 32. Registraris Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unk Unk

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 37898 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Re	eg. No.	
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)  Jeremy C. McWilliams	2. Date of Deal Month	Day Year	3. Time of Death 0029 hrs
Medical Exami	ici	Jeremy C. McWilliams  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	November	4c. County of De	
		Southern Maryland Hospital Clinton		Prince Geor	rge's
Funeral Director		5. Social Security Number 577–13–5783 6. Sex 1 Months 2 F 25 Yrs. 1 If Under 1 Year If Under 24Hrs Min 2 F 25 Yrs.	_	th(MM/DD/YYYY) 9. -1985 M	Birthplace (State or Foreign Country) laryland
ý		Usual Residence of Decedent  10a. State			10d. Inside City Limits
ne Maryland or 28a-f show any fied at once.	tor	MD PG Temple Hills	La	0g. Citizen of What C	1 Yes 2 No
th the Mar. 3a or 28a	I Director	10e. Street and Number 3462 Brinkley Rd. #304		USA	
	Funeral	11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes, 2 No  1 Yes, Give Year  1 Yes, Sive Year		14. Race - Am White, etc	
ours af atural camin	g p	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of value of the complete of the c		16b. Kind of Busines	
336 thin 72 hane. Than "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Teachers Aide	irea)	DC Public	: Schools
215-00 be filed wintal Hygien ked other ent, the M	Be Co	17. Father's Name (First, Middle, Last) RC McWilliams 18.Mother's Name Ora	*	Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		19a. Informant's Name/Relationship (Type, Print ) Ora Morgan/Mother  19b. Mailing Address (Street and Number or I 3462 Brinkley Rd. #30			
nore, I		20a. Method of Disposition  1 Natural 2 Cremation 3 Removal from State  Washington National  12-	Date -03-2010	20c. Location - City Suitland,	
Baltin permit. P Departme Importan injury or	d	4 Donation 5 Other Specify:  2. Sign- ure of Funeral Service Ucensee 22. Name and Address of Facility ROM	al Tay	or II FI	
	4	nonabl bull 10583 Middleport Lr.			
Physician /Medical.		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease a. Stab and Cutting Wounds	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Stab and Cutting volunds  Due to (or as a consequence of):			
	<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
ited d ansit		events resulting in death) Last  Due to (or as a consequence of):  d.			
760, cate be executed physician and the burial - transi	Medical	UNPENDED AMENDED			
760, icate be executed physician and the burial - transit		IF FEMALE:  23c. If yes, outcome of pregnancy  3b. Was decedent pregnant in the		23d. Date of deliv	·
Sox 687 death certific e attending I I for use as th	Physician	past 12 months?  4 Pregnant at time of death  5 Other (Specify)	ancy	Month	Day Year
BO)	hysi	1 Yes 2 No 9 Unknown 9 Unknown		1)	
P.O. Be that the de-	질	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?  robably 4 Unknown
cords, P.C law requires that has been signed to 2 should be deta	ge		24a. Was a		autopsy findings available
COF	Completed		autop	med? death	
tal Rec		25. Was case referred to medical 26.Place of Death (Check	1 Yes	2 No 1	Yes 2 No
Vita ysician his cer directe		examiner?		Residence 6 Ott	her:
	tion: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury FOUND:  28b. Time of Injury FOUND:  1 Yes 2 ✓ No 2345 brs	28d. Describe h Subject stab	ow injury occurred bed and Cut	
Division al or Attence s after death if Director: ed in by the	Certification:	3 Suicide 6 Could not be determined (Specific Marklat Forestly, And	or Town, S		Rural Route Number, City
To the Hospital within 24 hours. To the Funeral completely filled		4 Monicide (Specify) Multi-Family Apt.  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cause	e(s) and manner as st	tated.
To the within 2 To the complete	Medical	and manner stated.  29b. Skinnature and title of certifier  29c. License number		29d. Date signed (A	
		O.C.M.E.		November 24,	2010
	-	30. Name and address of person who completed cause of death (Item 23a)			
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
Sta Registr	100	31. Date filed (Month, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOYEM BER 30 20 10 11:12 AM Gilda Matthews Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar 1, 1925 **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F 313-20-0075 fndiana Director 85 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The mark of Health and Mental Hygiene ant: If item 27 is marked outher than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No Baltimore Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 USA 128 N. Lakewood Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) drapery store 12 self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie N. Robinson Sidney Lee Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya Matthews/daughter Lakewood Avenue Baltimore, MD 21224 26 N. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Signal to of Euneral Cervice License State and Address of Facility and 655 W. Baltimore Street Director MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician SHOCK Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Year Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Director: After this certificate 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death. completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**X**No Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending injury 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State, within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title

JEFFREY

31. Date filed (Month, Day, Year)

MD

ress of person who completed cause of death (Item 23a) (Type, Print)

BERNSTEIN

D 31674

7401 OSLER DRIVE

29d. Date signed (Month, Day, Year)

14:20

21204

11/30/10

TOWSON MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8,9,11,15,17,18&19a&B Per INF Colo 12/06/10 Hilly inne 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Novembour 22 2010 Patricia McLaughlin 0651 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner J. County of Death Baltimore Agnes Hospita 5. Social Security Number unk 6. Sex **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1948 Year 1948 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗓 F Months Hours July 28 Director 62 19348 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 😾 Yes 2 □ No Baltimore 10e. Street and Number 9 er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country? Funeral 22 S. Athol Avenue 21229 USA 72 hours after death unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces ð 1 X Never Married 2 Married unk Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) unk and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) -unk unk injury or other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked off any injury or other traumatic amont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ည - unk James A. McLaughlin Margaret Toal 19a. Informant's Name/Relationship (Type, Print)

St. Agnes Hospital Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C Stevenson RD. Severn. MD 21144 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛣 Other (Specify) in state ce License Signature of Funeral Sep State Anatomy Board 655 W. Baltimore Street Director ltimore. MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Athero scleratic Landiovascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown ase 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Can Ce 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 7/2009

State

within 2

29b. Signature and title of certifier

S

BEC

31. Date filed (Month, Day, Year)

Catun

2010

06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue

2. Registrar's Signature

MeLaughlin,

Baltinove

D005814

MD

21226

November 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MONTOVEMBER 1972 9:45FM 10 Leona Rose McCartney Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Haltimore **Examiner** 4b. City, Town, or Location of Death Saint Joseph Medical Center Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🛣 F Months Hours Min Mar 30, Ye 212-10-3975 Director Mary Land 90 โ′920 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🔽 No MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 D Brook Farm Court 21128 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Walter Droft Rose Piekarski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis McCartney/son 1418 Primrose Place Bel Camp, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Sther (Specify) Signature of Roma State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Interval Between. Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OBSTRUCTIVE LUNG DISEASE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year the Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by FIBRILLATION ATRIAL Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 npatient 2 ER/Outpatient 3 DOA 잍 Director: After this d in by the funeral di 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: **N**atural injury 5 Pending 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a

To the Funeral C

completed filled Medica 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 19 2010 D41410 mi ss(of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 TOGINDE HTA M.D. 7601 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26State of Warviand / Bepartment of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 28 2010 2:30 P BETTY L. MYERBERG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 11 SLADE AVENUE, #508 **BALTIMORE** Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday, 8. Date of Birth Hours 1 ☐ M 2**X**X 07/1071934 Director 212-30-7882 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or forther traumatic event, the Medical Examiner must be notified at any injury or forther traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director **BALTIMORE** BALTIMORE 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 SLADE AVENUE, #508 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. WHITE 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ DAVID SHEER MINNIE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE SNYDER/DAUGHTER FIVE OAKS COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM 11/30/2010 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySOL LEVINSON & BROS., Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD, PIKEŠVILLE, MĎ 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as consequence of) Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician at the detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence + Cher (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' Accident Suicide Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ufying Nu

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year,

20011781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State Registrar	State of Maryl		rtment of I			giene Reg. No. 2		37903
Physician/ Medical	1. Decedent's Name (First, Middle, L Edith Mille					2. Date of De Month De (embe	Day	Year	3. Time of Death
Examiner	4a. Facility Name (if not institution, gir SEASONS HOSPICE (	@NORTHWEST HOSPITAL			City, Town, or Location of Death  RANDALLSTOWN				MORE
Funeral Director	5. Social Security Number 6. 213 – 36 – 3761  Usual Residence of Decedent	Sex 1 □ M 2 <b>X</b> F 7. Age (In yr 95	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 03/10/		9. Birthp Count	lace (State or Foreign ry) NJ
he Maryland or 28a-f show notified at Director	10a. State 10b. County BALTIM		City, Town or Loc	ation LT IMORE				10	0d. Inside City Limits 1 ☐ Yes 2 🏋 No
death with the items 23a or 3 er must be no Funeral Di	10e. Street and Number 7 SUDBROOK LANE			10f. Zip Code 212	08		10g. Citizen of US		try?
, r ii	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		/as Decedent of H Yes, specify Cuba	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Dia	e - America ck, White, e : WHI	tc.
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)		(Give k	NOT use retired)	during most of work		16b. Kind of B		
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e, Mal and 2 shor Health and em 27 is n ther traum	19a. Informant's Name/Relationship GERI LIBERCCI/DAU  20a. Method of Disposition	JGHTER	5 HOUI	NDS HOLL	OW COURT,	OWINGS	MILLS, I	MD 21	117
Baltimore, permit. Page 1 and Department of Hea mportant: If item my injury or other once.	1 X Burial 2 ☐ Cremation 3 d 4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from State Ch	b. Place of Dispos ARI <sup>et</sup> TNGT HIZUK AMI	TRIV CEMENT JNO CONG	ERY 12/03	/2010	20c. Location -	RF MI	)
Ball permit Depar Impor any in	21. Signature I Funeral Service Lices 23a. Part 1. Enter the disease, or cor	el			ss of Facility SOL TERSTOWN			(41/6)	INC. MD 21208
Physician/ ⊱ Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  Atheroscus  Due to (or as a consi	rotic cur		70 :		est,	- 1	Approximate Interval Between Onset and Death
Examiner e	Sequentially list renditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consi							
60 ate be executed hysician and the burial-transit dical Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a conse	onsequence of):						
8760 tificate be exing physician as the burian Medical	IF FEMALE:	d			-				
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.  Medical Certificate: To Be Completed by Physician/Medical Exami	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of prec  1  Live Birth 2  F  4  Pregnant at time of 9 Unknown	etal death 3 🔲	Ectopic pregnand Other (specify)	су		23d. Da Mo	te of deliver	y Day Year
IS, P.O uires that the signed be lad be deta	Part II. Other significant conditions	contributing to death but not	derlying cause giv	23e. Did to	pacco use contribute to the cause of death?				
Records, The law require sate has been si page 2 should t									sy findings available pletion of cause of
of Vital Rec Physician: The law r this certificate has aral director, page 2 s: To Be Comp	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:		Oth	ace of Death (Check	( only one)			
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Division of tale of Attending P safer death.  al Director: After ted in by the funeral of the ted in by the funeral of the ted in by the funeral of the ted in by the funeral of the ted in by the funeral of the funera	3 Suicide 6 Could not 4 Homicide determined	be 290 Place of Injury At	home, farm, stree			28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural F	Route Number,
the Hospital hin 24 hours the Funeral mpleted filled	(Check 2 ☐ Medical Exan only one) 3 ☐ Certifying Nu	ysician: To the best of my kno niner: On the basis of examinal rse Practioner: To the best of	tion and/or investic	ration, in my opinic	on, death occurred at	the time, date at	nd place, and due	to the caus	e(s) and manner stated
To con	29b. Signature and title of certifier  MLYMPANNIM	Ď		29c. License	9 7465	2	29d. Date signed	(Month, Da	ay, Year)
. 1 1	30. Name and address of person who NS Rajapa S				5-203 /-	Ba Ihms	re, MC	). 212	09
3	31. Date filed (Month, Day, Year) DEC 0 5 2010	32. Registrar's Si	park						
DHMH 17 Rev 7/2009			ORIGIN	AL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NKele Mbai **Physician** Year norman 2 10 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Hos mb20 Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Days Hours Min. Director 02 03 Nov 22, infant 2010 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 □ Yes 2√□ No Howard Elkridge MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7031 Water Oak Road 21075 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📆 No Specify: black. er than "natural", of the Modical Exam Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Monte once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
infant infant infant infant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Erica Mansaray Nkele Mbai ဂ္ 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code)
5755 Cedar Lane Columbia, MD 21044 19a. Informant's Name/Relationship (Type. Print) Howard County General Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Funeral Service Licensee Ronal d.S. Wash-State Anatomy Board 655 W, Baltimore Street Director 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21201 Approximate Interval Between Onset and Death **Physician** Fetal disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of): Exami The law requires that the death certificate be execute resulting in death) Last Due to (or as a consequence of): burial-Box 68760 physician Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 ☐ Other (specify) P.O. the 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy page certificate Division of Vital 1 □Yes 2 this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 Pending 124 hours after death.

Refuneral Director: A pletely filled in by the fi death. investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) within 2. and manner stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8900 MD 31. Date filed (Month, Day, Year) egistrar's Signatur State Registrar

Please Type or Print in Black Indelible ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PENSION DECEMBER JOAN 6:07 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMURE UNIVELSITY OF MARYLAND MEDICAL CENTE If Under 1 Year 8. Date of Birth
(Month, Day, Year) If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □ F Days Months Hours 214-56-5172 Country) Director MD Usual Residence of Decedent show 10a. State be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 1902 West Lanvale Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc ò Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: "natural", ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Enoch Pratt Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Library llth grade na other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) is marked o မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic & James David Mack Frances Jefferson 19a. Informant's Name/Relationship (Type, Print) 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelica Powell-Daughter 1903 West Lanvale Street, Baltimore, Md 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 💢 Burial 2 🗌 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Druid Ridge 12/9/2010 Pikesville, Md Si of Funeral Service Licens 22. Name and Address of Facility |arch F/H West |300 Wabash Av March 4300 W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.

Immediate Cause (Prinal disease or conditions) Baltimore, Md Approximate Interval Between Onset and Death Physician/ MYELDED COMPLICATIONS ACUTE OF disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to in recliate cause. Enter Underlying Examiner Due to (or as a donsequence of, attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death
Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? hin 24 hours after death.

the Funeral Director: After this certificate I

mpleted filled in by the funeral director, pag Yes 2 A 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 K No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 Yes 2 No 5 Pending ☐ Accident☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 1386969327 TIM DECEMBER 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAUSO WACKER SOUTH GREENE MARYLAND BALTIMORE 21201 STREET. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 06 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of Maryla			of Health and of Death		iene ()   ()	37906
	Physici	an	Decedent's Name (First, Middle, L.)					2. Date of Deat Month	th Day Year	3. Time of Death
	/Medic			Uryear				11	22 2010	11:12 am
	Examir	ner	4a. Facility Name (If not institution, g			0 1.	wn, or Location of De	ath	4c. County of Dea	th
			Mercy Medic	al Center	took but to b		rimore			
п	Funeral Director			1 M 2 F F	. last birthday) Yrs.	If Under 1 \	Year If Under 24 H Days Hours M	in. (Month, Day,		thplace (State or Foreign ountry)
			Usual Residence of Decedent	85	)			Jan 14,	1925   Ne	w York
	how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Ba-1	cto	MD		Baltimo	ore				1√2 Yes 2 □ No
	vith th	by Funeral Director	10e. Street and Number			10f. Zip Co	ode	1	0g. Citizen of What Co	ountry?
	s 23s	rai	124 W. Franklin	T			21201		USA	
	iten de	i i	11. Marital Status unk 1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No	J.S.   13.	Was Deceden If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
99	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2🛣	No Specify:		Specify: b1	ack
Ŏ	within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28a-f ehow the Madical Examinar is untitle notilled at	Completed	15. Decedent's E		16a. Dece	dent's Usual C	occupation	vorking unk	16b. Kind of Business	rindustry unk
21215-0036	ithin 7	npie	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use r	done during most of w retired)	vorking dirk		unk.
2	filed w Hygier other th	Co	12	0						
and	pd otl	Be	17. Father's Name (First, Middle, Las Neal Pervis	")			18. Mother's N	lame (First, Middle, A	Maiden Surname)	
Maryland	hould d Me mark matic	ဥ	19a. informant's Name/Relationship	(Type Print)	10h Mailie	an Address (C		Mamie Tay		7.0.1)
<u>@</u>	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "naturel; or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examination into the notified at once.		Mercy Medical Ce					Baltimore	City or Town, State, .	
5	s 1 er f Hea item othe		20a. Method of Disposition		Place of Dispo	sition (Name	of !		20c. Location - City or	
Ê	Pages nent of I ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3   4 ☑ Donation 5 ☐ Other (Spec	1	cemetery, crer	natory or otne	r piace)			
Baltimore,	permit. Departm Importa eny inju		21. Signature of Euneral Service Lice	nsee Warento	r 22	Name and A	ddress of Facility	ard 655 W	Baltimore	Street
<u> </u>	80 = 8		Janna.				re, MD 21		Bulcimore	Bereet
			23a. Part1. Enter the disease or cor shock, or heart failure. Est only	plications that caused the dea	th. Do not ent	er the mode o	f dying, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
F	Physician		Immediate Cause (Finat disease or condition	GI Blee	ed .					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
		_	Sequenfially list conditions,	b. Due to for as a consa	outanea effe					
sir .	uted Insit	Examiner	Cause (Disease or injury		quisi nea suy					
o	le be executed ysicien end e burial-transit	Exa	that initiated events resulting in death) Last	c.  Due to (or as a conse	quence of):					
		icai		_ d						
89		Med	fF FEMALE:							
Box	eath certific attending pl	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1☐Live birth 2☐Fet		Ectopic pregn	nancy		23d. Date of del	
o.	by the a	Physician/Med	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specif	5/)		Month	Day Year
٦.	res that to igned by be detac	Ph	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	nderlving caus	e given in Part I	23e. Did fob	pacco use contribute to	the cause of death?
Vital Records,	ures Idbe	d by	Breast Can		•	,,	- <b>3</b>			obably 4 Unknown
ទូ	w requir	lete						24a. Was ar		Ifopsy findings available
2	ine lav cete has page 2:	Completed						autopsy perform	y prior to death?	completion of cause of
	certificete	0	25. Was case referred to medical				26. Place of D	1 ☐ Yes 2 eath (Check only one		2 No
> . o ;	r this certifice	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3□ DOA	Other		nce 6 □Other (Spe	cify)
	ng r		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe ho	w injury occurred	
ois i	Attending r r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not to			М	1 ☐ Yes 2 ☐ No			
DIVISION	or Atten efter deat Director: in by the	Certification:	4 Homicide determined		iome, farm, sfre	eet, factory, of	fice	28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
	spital ours i nerai filled		29a. Certifying P	nysician: To the best of my kn	nwiedne desth	Occurred at "	ne time data and all	on and due to the	uca/a) a=d == := := :	atata d
	555	Sica	(Check only 2 Medical Exa	niner: On the basis of examinand manner stated.	ation and/or inv	estigation, in	my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	to the cause(s)
-	24 Fletei	2				200 Li	cense number	20	nd Date signed (Mont	
	vithin 24 hours effect within 24 hours effect To the Funeral Direct completely filled in by	Medical	29b. Signature and fitte of certified			29U. LA	ochise mamber		d. Date signed (Month	h, Day, Year)
;	one nospital of At within 24 hours effer of To the Funeral Direct completely filled in by	Med	29b. Signature and fitting commen			D	006007	4 1	1/20/10	
3	within 24 To the Fu	Med	29b. Signature and first of carried 30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, I	D	006007	4 1	1/20/10	
1	within 24 me for the f		▶ Theled	I, MD, MPP	m 23a) (Type, 1	D	006007	4 1	1/20/10	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 December 8:48 РМ Charlotte B. Purdum Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist <u>Baltimore</u> If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number **Funeral** Country) Maryland Months Days Hours Min. 1 M 2 F 91 214-18-9189 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2 No MD Baldwin Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13908 Manor Road 21013 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Artist Self\_Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel D. Bottom Eva Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3825 Beatty Road; Monkton, MD 21111 Jean Vieta / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Episcopal Church 12/6/2010 Long Green, MD 21. Signature of Fund 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Varian Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed Yes 2 this certificate 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XXV0 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No completed filled in by the funeral 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After injury 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST 6701

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Margaret E. Reynolds December 2010 2:25 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🖼 F Hours 214-01-1341 Oct.26, 1913 Pennsylvania Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 \_\_Yes \_ 2 \boxed{X} No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: White 1 ☐Yes 2 K No Specify: 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy E. Tracey Clara Geaslen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Reynolds Husband 709 Maiden Choice Lane RGT323; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Park 12/6/2010 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility **Sterling Ashton Schwab Witzke** Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service M01050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) interline if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar in ust be notified at

with the Maryland

death v

within 72 hours after

h and Mental Hygie

permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is i

ould be f Mental I

Baltimore, Maryland 21215-0036

Examine Physician/Medical Be Completed by

burial attending physician for use as the buria signed by the a d be detached f page 2 should certificate funeral director, Certification: To this After 1 24 hours after deatle Funeral Director:

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	U	_
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown	n
	24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 ☑ No	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)	
27. Manner of Death  -1—Natural 5 Pending	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Work?  28c. Injury at 28d. Describe how injury occurred	

examiner?			26. Place of Death (Check only one)									
1 Yes 2⊟	No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)										
27. Manner of Deat  1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide	h 5 ☐ Pending investigation 6 ☐ Could not be		28b. Time of Injury M	1	lnjury at Work?			be how injury occurred				
4 ☐ Homicide	determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, street, fac y)	tory, offi	ice		28f. Location City or T	n (Street and Number or Rural Route Number, Town, State)				
29a. Certifier (Check only one)	1☐ Certifying Ph 2☐ Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occur tion and/or investiga	red at th tion, in r	ne time, d my opinio	ate and place n, death occu	e, and due to the irred at the tim	the cause(s) and manner as stated. me, date and place, and due to the cause(s)				
29b. Signature and	title of certifier	11/1/11/1	114/	29c. Lig	ense nun	nber		29d. Date signed (Month, Day, Year)				

State Registrar

filled in by

completely the

Medical

the Hospital

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-09264

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

udolph Davis		1- For State	te of Maryland /	Departmo <i>Certifica</i>			Mental I		2 2	0 1 0	37909
Physicia		Registrar  1. Decedent's Name (First, Middle	Last)					2. Date of De		Voor	3. Time of Death
ledical Exami		Rudolph	Davis	3		Raigns			er 2, 2010		1557 hrs
		4a. Facility Name (if not institution 4136 Hyden Court	, give street and number)			City, Town, or Lo Baltimore	ocation of Dea	ath	4c. Co	ounty of Death	1
Funeral Director				in yrs. last birti 7 9		Months Days	If Under 24H Hours M	U.m.	irth(MM/DD/	Foreig	thplace (State or gn puntry) NC
		Usual Residence of Decedent	XMZ	19	113.						,
v any		10a. State 10b. County		Oc. City, Town							10d. Inside City Limits
Aaryland 28a-f show 1 at once	for	MD N	A		ltim			· · · · · · · · · · · · · · · · · · ·	40 0111	of What Cou	1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	irec	10e. Street and Number				Of. Zip Code	205			U.S.A	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f shomatic event, the Medical Examiner, must be notified at once	Funeral Director	1437 East Eac	12. Was Decedent E	ver in U.S.		ecedent of Hispa	anic Origin? (	Specify Yes or N			ican Indian, Black,
death v	nne	1 Never Married 2 Mar	ried Armed Forces?	No	If Yes,	specify Cuban, I	Mexican, Puer	rto Rican, etc.)		White, etc.	
ral", o	by F	41	ced If Yes, Give Year or Dates:			s 2 X No				ecify: B1	
hours "natu		15. Decedent's Education (Speci Elementary/Secondary (0-12)	y only highest grade compl College (1-4 or 5+			Jsual Occupation of working life. D			166. Kind	of Business/I	industry
D36 thin 72 than	Completed	12th grade _	na		Tru	ck Dri	ver		Tru	cking	Company
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, L						me (First, Middle,	Maiden Sur	name)	
d be f fental arked event,	Be c	Rudolph Raig  19a. Informant's Name/Relationshi		196	Mailing Ar			Smith	ımber City o	y Town State	Zin Code)
MD 2 id 2 shoul lith and M m 27 is m	٩					· ' -		d, Parl			
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours at ment of Health and Mental Hygiene.  I ant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin		I inda Butler 20a. Method of Disposition	-	20b. Place o		n (Name of ceme		Date	20c. Loca	ation - City or	Town, State
MOFE Pages 1 nent of H nut: If i		1 Burial 2 Cremation 4 Donation 5 Other Spe		1			Vet.	12/14/	2010	Owing	s Mills,
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the L	1	21. Signature of Funeral Service L		1	22. Nam	e and Address o	West				
		23a Part I. Enter the disease, or c	molications that caused th	e death. Do no	1430	O Waba	sh Av	e, Bali	rest shock	e, mo	21215 Approximate Interval
Physician Medicul		ilure. List only one cause o						or respiratory a	root, onoon,	or mount	Between Onset and Death
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od ssit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):							
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Box 6876( death certificate the attending physed for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at tir	ne of death 5		death 3 (Specify)	Ectopic preg	nancy	Мо	enth D	Day Year
Box e death the atte	Physi	1 Yes 2 No 9 Unkn	own 9 Unknown		Other	(0,000)					
P.O.	by P	Part II. Other significant condition		ut not resulting	g in the unde	erlying cause giv	en in Part I.				the cause of death?
rds, P.C requires that been signed hould be dete		Chronic alcohol abuse						24a. Was			topsy findings available
cords law requir has been 2 should	Completed							auto	psy ormed?		completion of cause of
Vital Rec ysician: The list certificate		25. Was case referred to medical				26 Place o	f Death (Chec		2 No	1 🗸 Ye	es 2 No
Vital hysician this cert	o Be	examiner?	Hospital: 1 Inpatient	2 ER/0	utpatient 3		4		Residence	6 🗸 Other	r: Scene
og Ph og Ph After t	-	27. Manner of Death	28a. Date of Injury (Month, Day,Yea		Time of Injur	y 28c. Injury	at Work?	28d. Describe	how injury o	occurred	
tion ttendi death. ctor: /	atio	1 Natural 5 Pendir Pendir Investi	gation	- Se - Sec			s 2 No			7.5	
Divisi pital or At ours after d ieral Direct	Certification:	3 Suicide 6 Could determ		y - At home, fa	arm, street, f	actory, office bui	Iding, etc.	28f. Location or Town,		Number or Ru	ral Route Number, City
15 6 Pi	20	29a. Certifier	rsiclan: To the best of my l	nowledge dea	ath occurred	at the time date	and place, ar	nd due to the cal	ise(s) and m	anner as stat	ed.
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Exam	Iner: On the basis of examinand manner stated.	nation and/or ir	nvestigation	in my opinion, o	death occurred	d at the time, date	e and place,	and due to th	e cause(s)
7 4 3 4 8	Me	29b. Signature and title of certifier	and manner stated.	0.	_	29c. License					nth, Day, Year)
		Ca lun	ut	1 M	4)	O.C.M	.E.		Decem	nber 3, 201	10
(		30. Name and address of person v Zabiullah Ali, M.D. A	ho completed cause of deassistant Medical Exa		11 Penn (	Street, Baltin	nore MD 2	1201			
\ 	tate	31. Date filed (Month, Day, Year)				J., Janiii	.5,5, 1415 2				
Regis		DFC 0 6 2010	32. Registror's	garke							

State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3<u>0</u> 630 Month Physician/ PM Dixie Smith NOKMBE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE SINAI HOSPITAL OF BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 6 Sex **Funeral** Min. 1 □ M 2 🔀 F Hours (Month, Day, Year) 8/13/1948 Director 62 220-50-0556 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a 1 Yes 2XX No MD Baltimore Windsor Mill 10e. Street and Numbe 10g. Citizen of What Country? ms 23a o Funeral 8341 Liberty Rd. USA 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. , or þ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Desktop Publishing Co. Page Smith is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file ဂ္ Robert Smith Mabel Crenshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Joe Crenshaw/Cousin 11524 Bell Tower Ct., Richmond, VA 23233 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once, cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 12/7/2010 Lake View Mem. Park Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service 22. Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e Jate Cause (Final Ph\_sician/ EPSIS se e or condition liting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month 4 Pregnant at time of death 9 Unknown Day Year Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PULMONARY Hospital or Attending Physician: The law requires CHRONIC OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available HYPERTENSION 24a Was an prior to completion of cause of death? performed? Yes 2 No this certificate I 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number RES-000 QQ NOVEMBER 2010 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE SINAL nD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 12/2/2010 Physician/ 8:00 P M Sylvia E. Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01ney Montgomery Montgomery Co. General Hospital 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2XX Months Days Hours Min (Month Day Year) 6/13/1957 Country) Director MD 53 218-78-6536 Usual Residence of Decedent 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10206 Battleridge Place 20886 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Divorced Black. Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 General Employee State Roads Admin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Edward Luby, Sr. Beulah Anna Mae Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10206 Battleridge Place, Gaithersburg, MD 20886 Howard E. Smith/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth 1 Burial 2 X Cremation 3 Removal from State Carroll Crematory 12/8/2010 Winfield, MD 4 Donation 5 Other (Specify) f Funeral Service License Burrier due fa Tuneral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hock or heart failure. List only one cause diate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 0 2 No. After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 🗆 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred nours after death.

neral Director: After the filled in by the funera work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/2010 3 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18/01 Prince Phille Dr. State

√ DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ November 28201 1007 Grace M. Snyder Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Good Samaritan 8. Date of Birth 0/25/1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Social Security Number 6. Sex If Under 24 Hrs. **Funeral** Country) MD Days Hours 1 □ M 2 💢 F Months Min Day 213-26-8153 82 Yrs Director Usual Residence of Decedent 28a-f shov il Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X☐ No MD Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 714 Fairwind Drive 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Check Processor Bank of America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file hand Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည William Huesman Alice Delcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Snyder (son) 714 Fairwind Drive Bel Air, MD 21014 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney ValleyMem.Gar 12-02-2010 Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Sign tu e of Funeral Service / cen Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) myn Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit The law requires that the death certificate be executed Cause (Disease or Imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

1 Pregnant at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Month ed by the a Unknown 9 Unknown P.O. I n signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kid new DIFRATO Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sign e 2 should b Completed Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy , page performe After this certificate 2 🗌 No 1 Yes Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 400 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Vatural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No death. Investigation within 24 hours after death

To the Funeral Director;
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exemination and/or investigation in my action due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) phy sicion 40059540 November 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 5601 LOCHRAVEN BOUTEVARD 30HO, MD 21239 210 muns 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 6 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARVIN H. STEVER 1:45 PM DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE PARKVILLE 2512 WINDSOR ROAD 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F Months Days Min Hours Director 215-22-1301 Yrs 9/1927 PENNSYLVANTA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 X No MD BALTIMORE PARKVILLE 10e. Street and Numbe 5 10f. Zip Code 10g, Citizen of What Country? pe Funeral 23a must ! USA 2512 WINDSOR ROAD 21234 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces Black, White, etc. by 1 X Yes 2 ☐ No If Yes, Give ō 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", Completed 3 Widowed 4 Divorced WHITE Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Hygiene. CONSTELLATION ENERGY Elementary/Seconday (0-12) College (1-4 or 5+) SENIOR ENGINEER Ith and Mental Hygie 27 is marked other traumatic event, the YEARS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental rtant: If item 27 is marked မ NORMAN STEVER CLELA FELMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNN KIRKPATRICK/DAUGHTER 5173 ROCKY ROAD GLENVILLE, PA altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State è 1 X Burial 2 Cremation 3 Removal from State GARRISON FOREST Department of Important: If any injury or 12/13/2010 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, Signature of Funeral Service Licensee MOO217 TOWSON, 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) theroscherotie CArdw Unsau low DURAH Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician the burial Physician/Medical certificate be Box 68760 as attending IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for ( in the past 12 months? Pregnant at time of death Month Day Year signed by the a Yes 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Serile Dementia Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Annal Edrillation 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 obetes mellions death? After this certificate 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th Certificate: 28c. injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ģ 4 Homicide determined. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D158 54 Scot + AOHM Rd COCKOSCULLE Md Z1030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWRENCE BOHS ·MD State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death becember 2, 2010 Physician/ Marjorie Louise Shields 11:12P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min 1 🗆 M 2 🗶 F 216-12-3998 8/15/1920 Maryland Director 90 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shormust be notified at 10a. State Director Maryland | Baltimore 1 🗌 Yes 2 🙀 No Parkville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 8820 Walther Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 2 No ☐ Yes 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and is ental Hi fitem 27 is marked of rother traumatic even ည Henry B. Meagher Laura F. Weisbaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 of Health a 2105 Starmount Lane Debbie Hogan / Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other placel Department of Important; If it any Injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wmu disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an yes 2 W il or Attending Physician: " after death. Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury/occurred 1 Natural 5  $\square$  Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8303 December 3 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 6701 N. Charly ST TOWSON MA 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08688 State of Maryland / Department of Health and Mental Hygiene Joseph Steven Tumminello Certificate of Death 1- For State Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1902 hrs November 12, 2010 Joseph Stven Tummenello <sup>ন্</sup>cal Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Unk 6. Sex **Funeral** Hours Months Days Mar 26, 1943 67 Director 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 No Baltimore or 28a-f show MD Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe IISA 21231 519 Chester Street 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status unk Marrie If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Yes 2 Naunk Specify: white Yes 2 X No specify: If Yes, Give Year 4 Divorced ۵ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) unk unk during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) <u>unk</u> 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Penn Street Raltimore, MD 20c. Location - City or Town, State O.C.M.E. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Oner Specify: State Anatomy Board 655 W. Baltimore Street 21. Sig of the lice Line Baltimore, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval rt I, Enter the en Onset and **Physician** failure. List only one cause on each line. Death /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician for use as the burial -23d. Date of delivery Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) a signed by the atte requires that the death 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Vunknown ≥ Completed 24b. Were autopsy findings available 24a. Was an funeral director, page 2 should prior to completion of cause of autopsy performed? death? certificate has 1 🗸 Yes Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, Division of Vital Be Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA 1 🗸 Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification 1 Yes 2 No 1 V Natural 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 \_\_ Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c License numbe 29b. Signature and title of certifie OGME November 13, 2010 O.C.M.E. of death (Item 23a) and address of person who completed on 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 32. Registrar's Signature 31. Date filed (Month 06 2010

DHMH 17 Rev 1/2001 OCME 2006

State Registra

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year SIE LA PP 2130 ELEMBON 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moscon Cours BATTMORE MARTLAND NIVORSIM If Under 1 Year 7. Age (In yrs. last birthday) 82 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number Months Days Hours Min. 8-20-1928 219-22-3489 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Anne Arundel Linthicum 1 Yes 2X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 208 Hawthorne Road 21090 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 ☐ Divorced Specify: white "natural", Completed 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Clinical Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Henry Brown Bessie Mae **Bradley** t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorie Forte / daughter 7549 John Picket Rd Woodbine MD 21797 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 12/6/2010 Catonsville MD Metro Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signar e of Fun and 3 Kirkley-Ruddick Funeral Home M01364 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ RACHEAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VELK MASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 NiNo ξ Month Year Pregnant at time of death 5 Other (specify) Day detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 Yes the Hospital or Attending Physician: ours after death.

eral Director. After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending М Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Dire Medical 29a. Certifier 1 🚝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 0

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BALTIMORE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rita H. Weslow 2010 Dec 12:15A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brinton Woods Health Care Ctr Sykesville Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Year) 19<u>17</u> March 6 1 □ M 2 **X** Months Hours Min. Mary Land 215**-** 18**-** 3738 Director Usual Residence of Decedent 28a-f shov 10b County 10c. City, Town or Location 10a. State must be notified at 10d. Inside City Limits Director Baltimore Woodstock 1 Yes 2 X No Maryland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10720 Davis Ave. United States 21163 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2XXNo If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 XWidowed 4 □ Divorced Specify Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene.
is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) B & O Railroad the 12th clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked or any injury or other traumatic eve မ Everisto Graziani Catherine Zavi rusha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother Franklin Warfiled 10720 Davis Ave. Woodstock, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State South Carroll Crematory Dec. 6,2010 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Jure of Funeral Service Lie 22. Name and Address of Facility Durrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Sykesville, MD 21784 P rt 1. Inter the disease, or complications that ock, or heart failure. List only one cause on a death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Retween Immer ia Cause (Final diseas or condition resulting in death) Onset and Death KIWAK Pnysician/ MONTO Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Day Pregnant at time of death detached a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

with the Maryland

death v

72 hours after

Baltimore, Maryland 21215-0036

physician ate has been signed by page 2 should be detact this certificate /s after deau... ral Director, After this Communication by the funeral director, pr completed filled in by

Certificate:

Medical

27. Manner Death Matural

29a. Certifier (Check 29b. Signature ap

5 Pending Accident 6 Could not be 3 Suicide 4 Homicide determined

title of

28a. Date of injury (Month, Day, Year) Investigation

injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work? 1 ☐ Yes 2 ☐ No

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

20806

29d. Date signed (Month, Day, Year) 2010

21136

28f. Location (Street and Number or Rural Route Number

City or Town, State)

Restalston

and address of person who completed cause of death (Item 23g) (Type, Print) BUSIOLESS

32. Registrar's

State Registrar

24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year John Washington Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey
5. Social Security Number House Baltimore 7. Age (In yrs. last birthday) If Under 1 **Funeral** Year If Under 24 Hr Days Hours Mir 8. Date of Birth Birthplace (State or Foreign Country) **X**□ M 2 □ F Months (Month, Day, Year) Director 217-16-9836 Yrs. 93 08 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1X Yes 2 ☐ No 10e. Street and Number Funeral 10g. Citizen of What Country? 29 North Kossuth Street 21229 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working 12th grade College (1-4 or 5+) Fork Lift Operator Locke Insultator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Miles Lillie Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Washington-Daughter North Kossuth Street, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Loudon Park 12/7/2010 Baltimore, Md 21. Sig atus df Funeral Service Licensee 22. Name and Address of Fa arch F/H We 300 Wabash ss of Facility
West Ave. Baltimore, Md 23a. Par 1. Enter the bisease, or complications that caused shock, or heart failure. List only one cause on each ine. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and leth Ph, sician/ ODro disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) NHN WASHING FOR Records, P.O. Box 68760 Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 1 ☐ Yes 2 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **To the Funeral Director:** After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No after death.

Director: After this certificate I 2 🗆 No 1 Yes Vita 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: ည Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence o 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending work' 2 Accident Investigation 1 Tes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) MD 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) Elizabeth Tso MD Richey Hospice 838 N. Eutaw St. Balfimore MD 21201

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 6 2010

3

DHOP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5:50 33 2010 Terrance Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Charles Village Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 11nk 5 Social Security Number 6. Sex **Funeral** 1∰M 2□F Days unk 228-58-7086 41 Aug 28, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County Worle 10a. State other than "natural", or Items 23s or 28s-f shower, the Medical Examiner must be notified at 1 Yes 2 □ No MD Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 W. Franklin Street 21201 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No unk
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be and Mental I ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 2327 N. Charles Street Baltimore, MD 21218 Future Care Charles Village 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H Important: If Its any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥ Other (Specify) in state 21. Signature Funeral Service Director State Anatomy Board 655 W. Baltimore Street 23a. Parkt. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AIDS **Physician** HIV years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ş Dnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️No 24a Was an s certificate has t director, page 2 s 1 Tyes 2 No Vital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Noursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No ٩ Division of After the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. Diractor: / investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter or To the Funeral Dirac completely filled in by 4 Homicide 29a. Certifier 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Than Poon, m) 057088 NOV 23, 30. Name and address of person mo completed cause of death (Item 23a) (Type, Print) # 601 Pan Baltimon, mi) 301

State

Registrar

31. Date filed (Month, Day, Year)

06 2010

Silliams

#32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan		partment of I e <i>rtificate of I</i>		, ,	201	n 3	7921
	Physicia	an/	1. Decedent's Name (First, Middle, Las	I: I		or tirroute or i	Death	2. Date of Dea	Day /	Year A	ime of Death
Ŋ.	Medi Examii		4a. Facility Name (if not institution, give				or Location of Death	Decem b	4c. County of		:04 AM
	Funeral		5. Social Security Number 6. So	ex 7. Age (In yrs. Ia			Buenie If Under 24 Hrs.	8. Date of Birtl		ARUN  9. Birthplace (S	
	Director		217-26-1850 1 Usual Residence of Decedent	□M2\\ F\ 80	Yrs.	Months Days	Hours Min.	2-25-19	30°	Country)	
	death with the Maryland items 23a or 28a-f show ner must be notified at	Funeral Director	10a. State 10b. County Anne Art	undel 10c. City	len B	Location urnie					ide City Limits
	h the M ka or 28 be not	al Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh		163 222110
	ath wit ems 2: r.must	uner	7855 Crilley Rd	Apt 402  12. Was Decedent Ever in U.S	13	21060	lianania Orlain? (Sna	sifu Voc ex No	USA	·	
21215-0036		Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	. 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 → No		Rican, etc.)	Black,	American India White, etc. white	an,
$\frac{1}{2}$	72 hor	mple	15. Decedent's Ed (Specify only highest gra	de completed)	(Givi	edent's Usual Occup e kind of work done o DO NOT use retired)	during most of working	ng	16b. Kind of Busi	ness Industry	
E7	J within ygiene. her tha t, the I	S	Elementary/Seconday (0-12)	College (1-4 or 5+)		Home make:			Home Ma	ker	
$E \sqrt{\epsilon}$	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Henry L. Schafe:	c			18. Mother's Name Evelyn	(First, Middle, M	,		
Σ	and 2 should Health and M em 27 is mar ther traumati		19a. Informant's Name/Relationship (Ty H. Erle Schafer/I			iling Address (Street a				e, Zip Code)	
$N_i$ / $56$ / Baltimore.	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Sther (Specify	Removal from State C6	emetery, cre	position (Name of ematory or other place en Mem Pr	ce)	ate /2010	20c. Location - Ci		ite
W/ Balt	permit. Departr Importa any injt		21. Signatur of Fureral Prvice Vicens	M0136	64	22. Name and Addres	ss of Facility Kirk	ley-Ruc	ldick Fun	eral Ho	ome
d	Pnysician/ j Medical		23a. Part I. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused the death the cause on each line.  a. Due to (or as a consequence)	. Do not en					Approx	ximate al Between and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conseque	ence of):						
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1760	icate be executed g physician and s the burial-transi	edical		d	_						<u> </u>
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 hoperis? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan  1  Live Birth 2  Fetal  4  Pregnant at time of de	death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date o Month	,	Year
s, P.O	ires that t signed by d be deta		Part II. Other significant conditions con Myo cardial int	ntributing to death but not result	Iting in the	underlying cause giv	en in Part I.	23e. Did tob	es 2 No 3	te to the cause	
Record	he law require has beer age 2 shou	Completed by	• /					24a. Was ar autops perform	24b. Were prior deat	e autopsy findii r to completion th?	ngs available of cause of
Ital	ician: Dertifica	Be	25. Was case referred to medical examiner?	lospital: ( )			ace of Death (Check o	1 ∐ Yes 2 only one)	2X No 1 L	Yes 2 □ No	1
of V	g Phys er this eral dir	e: 10	27. Manner of Death	28a. Date of injury 2	8b. Time o	of 28c. Injury	4 Nursing Hom		nce 6 Other (S	pecify)	
ion	tending death. tor: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 □ No	od. Describe not	w injury occurred		
Divis	ital or At ins after or al Direct led in by		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, sti	reet, factory, office	29	3f. Location (Str City or Town,	eet and Number or State)	Rural Route N	lumber,
	the Hospi iin 24 hou the Funer	Medical	Uneck 2 L Medical Examin	cian: To the best of my knowled er: On the basis of examination a Practioner: To the best of my k	and/or inves	stigation in my opinior	n death accurred at the	a time data and	I place and due to	the equipolal and	d manner stated
	No To To To To To To To To To To To To To		29b. Signature and title of certifier  Author	shew, M.D.	,	29c. License	240	$\mathcal{I}^{29}$	Od. Date signed (M. De Cember	onth, Day, Year,	) )(0
3			39. Name and address of person who co	301 Hospit	al D	rive, Gla	en Burn	ie, M	D 210	6/	
1	State Registra	9	31. Date filed (Month, Day, Year)  DEC 0 6 20	32. Regintrar's Si natur	e	back		£			
DH	ML 17 Day 7/00	20		1	1 1	7					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1,2010 2328 December Anna Anita Zoppo Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balto, Parkville 8011 Highpoint Road 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Country) Maryland 1 □ M 2🗶 F .1924 Director 86 \$eptember 219-12-7994 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2X No Parkville Md. Balto. 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Funeral "natural", or items 23a USA 8011 Highpoint Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?, 1 Yes 2 No 1 Never Married 2 Married by Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Specify Completed 3 XWidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 8th College (1-4 or 5+) Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Genieve Nigro Leo Ambrose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Md. 21234 DTR. 3415 Northwind Road Margie Zoppo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-6-2010 Parkville,,Md 4 Denation 5 Other (Specify) Moreland Memorial 22. Name and Address of Facility Schimunek FuneralHome 21. Signal e of Funeral Service Lic 9705 Belair Road Nottingham, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ONGESTIVE MONTES disease or condition Medical resulting in death) Medical Examiner Due to (or as a consequence of) schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month 5 Other (specify) Pregnant at time of death Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my browledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2

To the F

complete 9b. Signature and title of Pertifier 29d. Date signed (Month, Day, Year) Dec 3, 2010 and address of person who completed cause of death (Item 23a) (Type, Print) SCHWARTZ

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 4 **ELENA** ZUKAS Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🛣 F Months Hours Director 3/16/1914 Country) LITHUANIA 067-26-3272 96 Usual Residence of Decedent 10a. State and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD BALTIMORE TOWSON 1 ☐ Yes 2 💢 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 23 ACORN CIRCLE APT. 204 21286 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 X No 0 Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes Give "natural", 3 M Widowed 4 □ Divorced 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE Year or Dates the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) 4 YEARS LANGUAGE TEACHER PUBLIC SCHOOL SYSTEM event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ KOSTAS EFIMAVICIUS MARTJA MASLOVATTIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau JOHN ZUKAS/SON 5903 WAKEHURST WAY BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) MORELAND MEM. PARK 12/7/2010 HILLENDALE, MD 21. Signature of Funeral Service Licensee mOO2 17 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eith Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 C Ectopic pregnancy 5 Other (specify) Pregnant at time of death Day Year the 9 Unknown Unknown P.O. þ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 2º☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy certificate performe 1 ☐ Yes 2 ☐ No 2 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of : After 1 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural iniury within 24 hours after death To the Funeral Director: A 2 Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my online, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nune

32. Registrar's Signature

au

31. Date filed (Month, Day, Year)

MI

29d. Date signed (Month, Day, Year)

-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Kathleen Andervon 1:55 PM 2010 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death lontgomery Montgomery 7. Age (In yrs. last birthday) Hockville Hospice If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 24 Hrs. Min Hours Director Yrs. 578-56-550 Virginia Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Sant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Rolling Road 20877 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Non Profit Associations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Olaf Swenson Margaret R. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Andervont/husband 106 Rolling Road Gaithersburg, Maryland 20877 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 11/15/2010 Woodbine, Maryland 21. Sig ture of Funeral Service Licer Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M uanita Thomas M00957 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Month Day Year 1 Yes 2 2 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed?

Yes 2 No prior to completion of cause of death? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 🛛 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 1 Natural work? 1 \sqrt{Yes} 2 \sqrt{No} 5 Pending injury Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined hours after within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The definition of the desired of the money of the desired course at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R120698

State Registrar

10

6001 Muncaster Mill Road Rockville, Maryland

Sher 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signature

Nicole Christenson

T 6 2010

November 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov 24 Physician/ <sup>ay</sup>2010 10:10 AM Abucevicz Alice Roberta Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 13701 Abucevicz Rd. NW Mt. Savage 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 | M 2 | F Months Days Hours Min. 214-28-6926 1928 MD 82 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Mt. Savage MD Allegany 1 Xes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13701 Abucevicz Rd. NW 21545 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S ıral", or iten I Examiner n 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify. white "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed if Health and Mental H item 27 is marked ot ပ္ Bertie (Kellar) Morgan Morgan David Morgan, Jr. 19b. Mailing Address (Street and Number or Rural Route Num MT City Savages MDc.2:1545 13701 Abucevicz Rd. NW Cumberland MD 2 19a. Informant's Name/Relationship (Type, Print) George Abucevicz Sr. <del>1502</del> husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot cemetery, crematory or other place)
Restlawn Memorial Gardens Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/2010 MD LaVale 4 Donation 5 Other (Specify) Pignature of Funeral Service Licensee 22. Name and Address of Furneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate shock, or heart failure. List only one cause of ach line Interval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for an a consconence of signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnar 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month Pregnant at time of death should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen : 245. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autonsv page 2 performed? Yes 2 N 1 Yes 2 No No within 24 hours after deam.

To the Funeral Director: After this certifica 25. Was case referred to predical 26. Place of Death (Check only one) Be Hospital Other: 2 1 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier "Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who SHOPL

DHMH 17 Rev 7/2009

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State

Registrar

32. Registrar's Signature

6

Division of Vital Records, P.O. Box 68760	
to the Hospital or Attending Physician; The law requires that the death certificate be executed	-
within 24 hours after death.	

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			For State	State of Ma	aryland		artment of F <i>tificate of L</i>	Health and N	Mental Hy	_	2010	37926
			Registrar  1. Decedent's Name (First, Middle, La	st)		Cer	uncate of L	Jean .	2. Date of De	Reg. N		3 Time of Death
	Physicia Medic			Samuel C	. And	ers			Novemb	oer <sup>D</sup>	28 2010	2125 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, giv 104 Decker Stree	,	4b. City, Town, or Location of Death Elkton					4	c. County of Deat	n
	Funeral		5. Social Security Number 6. S		e (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit	rth	9. Birt	hplace (State or Foreign
	Director	219-30-3761   TEST M 2 L F   83 Yrs.   WORLD'S LAYS HOURS   WIII								2, Year)	927 Pen	nsylvania
	yland -f shov ed at	ctor	10a. State 10b. County		10c. City,	Town or Loc	cation	- · · <del>-</del>				10d. Inside City Limits
	he Mar or 28a	Director	Maryland Ceci  10e. Street and Number	1	E	1kton	10f. Zip Code			10- 0	itizen of What Co	1 X Yes 2 □ No
	s 23a o	Funeral	104 Decker Stree	t			21921	_		_	United St	· ·
	r item		11. Marital Status	12. Was Decedent E Armed Forces? 1 \( \subseteq \text{ Yes} \( 2 \subsete \text{X} \)	ver in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White	ican Indian,
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and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) Clayton Anders					18. Mother's Name		, Maider		
aryl	nould t		19a. Informant's Name/Relationship (1	ype, Print)	1	19b. Mailin	a Address (Street a	Lizzy I		er. City o	er Town, State, Zin	Code)
Ž,	ind 2 sl lealth a m 27 is		Margaret Anders/	Wife		104	Decker St	reet, Ell			21921	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1  Burial 2  Cremation 3		cen	netery, crem	sition (Name of natory or other place			l	_ocation - City or -	
altir	permit. Pa Departme Importan any injury once,		4 ☐ Donation 5 ☐ Other (Special Signal are of Funeral Service Licen		K. A	. Ferr	S & CO., 1	nc. 29. 2	2010 cks Hom	l V ne fo	Vest Ches	ster, PA als, P.A.
m	Pe a L L		Donud l	Hickn			103 W.	Stockton	Street	, E		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	plications that caused ine cause on each line	the death.	Do not ente	r the mode of dying	g, such as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a	consequer	nce of):	acres	-			-	
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	e executed cían and urial-transit	<u>a</u>	resulting in death) Last	Due to (or as a	consequer	nce of):	_					
68760	cate by physical phys	ledic		d				<u> </u>				
89 x	n certif tending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of			Ectopic pregnance	,			23d. Date of deli	very
. Box	ne deat / the at ched fo	Physician/Medic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5 🗌	Other (specify)	*			Month	Day Year
P.O.	s that the	by P	Part II. Other significant conditions of	•	t not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
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E E	stan: Ir		25. Was case referred to medical examiner?	-			26. Pla	ce of Death (Check	1 \(\superstack \text{Yes}\)	2 🔀 N	lo 1 L Yes	2 LJ No
<b>&gt;</b>	Physic this co	욘	1 ☐ Yes 2 No 27. Manner of Dea h	Hospital: 1 ☐ Inpatie 28a. Date of injury		R/Outpatient	3 DOA Othe	4 ☐ Nursing Hor			6 Other (Specif	y)
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Division of Vital Records,	to the hospital or Attending Prystolan; The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home (Specify)	e, farm, stree	et, factory, office	2	28f. Location (S City or Tow		nd Number or Rura )	l Route Number,
	bours hours ineral	Medical	29a. Certifier 1 Certifying Physics	sician: To the best of n	ny knowled	ge, death o	ccured at the time,	date and place, and	I due to the ca	use(s) ar	nd manner as state	ed.
1	the Hithin 24 the Fu		(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nurse  29b. Signature and title of certifier	ner: On the basis of ex se Practioner: To the b	amination ar est of my kr	nd/or investig nowledge, de	eath occurred at the	time, date and place	, and due to the	e cause(	s) and manner as s	
	5. <b>5</b> 8. 5		O boyle	40	MI		29c. License	16075		29d. Da	te signed (Month,	Day, Year)
		ŀ	30. Name and address of person who		ath (Item 23	Ba) (Type, Pr		Main:		11-	h - 14	UI
	Stat	e	31. Date filed (Month, Day, Year)	Sayga(	) Signature	• (			۲ , ۲		1001	
	Registra	r	DEC (	3 7010	ensua.	A.	pares		_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Horace Walter Brooks 10, November 2010 8:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Deatl 4c. County of Death 6100 Westchester Park Drive Prince George College Park 5. Social Security Number 8. Date of Birth
(Month, Day, Yea
April 20, If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Asheboro, Director 83 Yrs 579-30-2899 Usual Residence of Decedent or 28a-f show e notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director 1 X Yes 2 No Maryland Prince George College Park 10 10f. Zip Code 10g. Citizen of What Country? must be 23a 6100 Westchester Park Drive 20740 United States ral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify: "natural", If Yes, Give 3 - Widowed 4 - Divorced Year or Dates American traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department of Defense Intelligence Analyst Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, is marked o 2 permit. Page 1 and 2 should bt Department of Health and Men Important: If item 27 is marke any injury or other traumation William P. Brooks Wilhelminia E. Sasportas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer L. Eaton, 440 L Street NW # 507 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Nov, 30, 2010 | Cheltenham, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Metastatic Prostate Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if a y, leading to inmediate cause. Enter Underlying Cause (Disease or linjury Examiner Que to (or se a noneequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary Fibrosis the attending physician and the for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perforn death? Yes 2 No nours after death.

neral Director: After this certificate
dilled in by the funeral director, pa 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 X No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 M Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Contributing Nurse Practioners To the best of my knowledge, death occurred at the time, date and plane and due to the To the I within 2

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Rupa A. Varma 31. Date filed (Month, Day, Year) NOV 1 9 2010 coma

1221 Mercantile Lane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D43211

Largo, Maryland

20774

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 U State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Eric Berry November 3:05  $P^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3909 23rd Parkway Temple Hills Prince George **Funeral** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
May 30, 1958 9. Birthplace (State or Foreign 1 🛂 M 2 🗆 F Months Days Hours Country) Director 578-78-5128 52 Yrs. DC Usual Residence of Decedent ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Prince George 1 X Yes 2 No Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3909 23rd Parkway # 11 20748 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 ☐ Married ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Fire & Hazmat Inspector Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harvey Berry Janice Joyner 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Co  $3909\ 23rd\ Parkway\ \#\ 11\ Temple\ Hills,\ Md.$ Janice Berry - Mother 20748 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 9 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Landover, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hypertensive Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Diabetes 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown **Mellitus** 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending ☐ Accident ☐ Suicide Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) SOCONICWO. D0055314 November 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Sylvester Okonkwo, M.D. 6192 Oxon Hill Rd. Suite 507 Oxon Hill, Md.

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Registrar

31. Date filed (Month, Da NOV 2 2 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 15, 2010 6:15 p<sup>M</sup> ROLAND BARNES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOWARD COLUMBIA LORYEN NURSING FACILITY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1**√** M 2 □ F Yrs. 1926 Liberia Director Feb. 19, 138-90-4738 84 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extendiner must be notified at once. 10c. City, Town or Location 10a. State 1 AYes 2 No Director Jessup Md. Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #114 20794 9950 Guilford Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □ No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 5+ Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Rose Watkins Rufus Barnes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9950 Guilford Rd. #114 Jessup, Md. Eudora Barnes/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Rockville, Md. 4 Donation 5 DOther (Specify) Parklawn Memorial Pk. 11-27-10 22. Name and Address of Facility 21. Signature di Funeral Service Licenses Capitol Mortuary, 20002 | 1425 Maryland Ave., NE Wash., DC complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) pneumonia **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine and the burial-tra Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Illnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Atter this certificate has been s funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 1 ☐Yes 2 ☐No investigation 24 hours after death. Funeral Director: A filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed signed by the a

Division of Vital Records, P.O. Box 68760,

death with the Maryland

Baltimore, Maryland 21215-0036

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certific

29d. Date signed (Month, Day, Year)

have and address of person who completed cause of death (Item 23a) (Type/Print) 34

State Registrar

completely

within 2 To the F

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November <sup>Day</sup>1, 2010 Physician/ 9:48 A James Patrick Burke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles La Plata 10690 Prince Charles Drive Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe Sex 1X M 2 F 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. Hours 7/20/1916 Pennsylvania Director 578-26-7667 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a. State Maryland Director La Plata 1 🗆 Yes 2 🛗 No Charles 10f. Zip Code 20646 0 10e. Street and Number 10g. Citizen of What Country? United States items 23a or ner must be n 10690 Prince Charles Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 XYes 2 No Black, White, etc. ö þ 1 X Never Married 2 Married White Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 XNo Specify: If Yes Give Specify: "natural", Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. State Department Assistant Chief of Records 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other ဂ္ Florence Dixon Daniel Harold Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10690 Prince Charles Drive, La Plata, MD 20646 Martina O'Neil/Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 11/23/2010 Cheltenham, MD 22. Name and Address of Facility 3rinsfield-Echols F.H., P.A., e of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0174 & M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions Examine Due to for as a conse uence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Month Pregnant at time of death 2 No Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 2 No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performe Yes 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 1 Yes 욘 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending after death. 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 469 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Collins , 3400 Old Washington Road, Waldorf, MD 20602

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year,

NOV 17

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard Bee .2010 **Bland** November 11:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 420 Fairhaven Road Tracys Landing Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 Hours Min. (Month, Di September Country)
Washington DC 226-50-7839 79 **Director** ,1931 Usual Residence of Decedent f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Tracys Landing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 420 Fairhaven Road 20779 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 X Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natu iury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Attorney Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Bland Agnes Wynne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Bland, III/Son P.O. Box 1525, Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place)
Cedar Hill Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22AREHART-ECHOLS FUNERAL HOME, P.A. M00945 211 St. Mary's Ave. La Plata MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to for as a consequence of if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) Year signed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER, COR Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CANCER 24a. Was an page 2 s autopsy performed? Yes 2 A No this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home A Residence 6 Other (Specify, 1 ☐ Yes 2X No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending iniury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifig 29d. Date signed (Month. Day, Year) November 16, 2010

Registrar

31. Date filed (Month, Day, Year)

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ARNOLD, MD

and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 11/1/10, M.S. Kent Co. Amended #5 Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DILLINGS MHOL 1:30 a M KIMBAL 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23502 KENT LOVELY HESTERTOUN 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months 21 20 7497 Usual Residence of Decedent Days Hours Min. Director J4.45 15 1928 10c. City, Town or Location show 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at KENT Director MD 1 ☐ Yes 2 No CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 23502 LOVELY LANE 21620 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 December 2 □ No HYes, Give Year or Dates: /946 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: WHITE 3 Widowed 4 Divorced item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GENELAL ELECTRIC 12 ECHANICAL ENGINEER سنوا 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth Be BLLLING HARLAND STONE HOUSE မ SIBYL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REYNOLDS HELEN 23502 LOVELY GANE 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 important: If its any injury or o 1 Burial 2 Cremation CTE 10/30/2010 CHESTER, MD 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MARVIN V. WILLIAMS, JE FUNSAL DIRECTOR MOO 625 V. Wit 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 130 SPEEK RD CHESTERISMUMD Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYELOGENOUS LEUKEMIA month /Medical Due to (or as a consequence of) Examiner MYELOBYSPLA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: use. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZOIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)
Helen A Noble 122 Speer Re Md 21620 Year) 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 1 1 0 9 - 2 0 1 0 Physician/ 11:09A M William E. Brooks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Country) 1 □XM 2 □ F 0/40nth 0 2 4 V A 86 229-22-1658 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examples. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 X Yes 2 No DCWashington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 USA 803 Quackenbos Street, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, was becent Ever in 6.5 Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1944 Black, White, etc þ 1 Never Married 2 X Married Specify: Black 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Dietician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Rollins ၉ James L. Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001119a. Informant's Name/Relationship (Type, Print) Quackenbos St., NW, Washington, DC 803 Margaret Brooks/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 V Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) incoln Mem. Cem. 11-19-201QSuitland, Maryland 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave.,Suitland, MD MO1616 1) Mra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph\_sician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed 1 🗌 Yes \_2 🗌 No Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: ၉ 1 Tes 2 🔀 No 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of completed filled in by the funeral Certificate: 28d. Describe how injury occurred 1 🛛 Natural injury 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar'

HAMPOVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 1:59 Kenneth W. Barnes Jr. November  $A^M$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Prince George's Hospital Center Cheverly 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan. 7, 1953 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 🛂 M 2 🗆 F Hours Jan. DC **Director** 579-70-8007 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No Capital Heights Prince George Maryland 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number Funeral items 23a United States 131 Cindy Lane 20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 6 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kenneth W. Barnes, Johnnye Mae Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 131 Cindy Lane Capital Heights, Maryland 20743 Melanie F. Barnes - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) November 2010 Donation 5 🗆 Other (Specify) Heritage Memorial Waldorf, Maryland 22 Name and Address of Facility Stewart Funeral Home, Sig of Funeral Service Lice 4001 Benning Road NE Washington, DC Part 1 Anter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, 1 heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner ERE BRAL VASCULAR ACCIDENT physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be a thin 24 hours after death, the Funeral Director: After this certificate has been signed by the attending physicia mpleted filled in by the funeral director, page 2 should be detached for use as the burn mpleted filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Yes 2 ☐ No 1 Yes 2 L 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗡 No 욘 1 🗌 Inpatient 2 🕰 ER/Outpatient 3 🗌 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 
Yes 2  $\square$  No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 炮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and Ne of certi 30. Name and address of person completed cause of death (Item 23a) (Type; Print) Cheverly mo2078S GRIFIN 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 11:20 AM November Genevieve Carlene Berry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert County Memorial Hospital Prince Frederick g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Funeral (Month, Day You Year 1936 1 □ M 2 🖾 F Months Days Hours Min. Maryland Director 217-34-3420 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 ☐ No Calvert Huntingtown Maryland 9 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 23a Funeral 3682 Solomons Island Road North 20639 United States items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 Yes 2 No Specify. "natural", 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12th Self-Employed Bus Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John S. Smith Ida Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4917 Smithwick Lane Bowie, Maryland Lincoln T. Berry - Son 20b. Place of Disposition (Name of cemetery, cematory or other place)
Calvery United Church
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State November 20 1 X Burial 2 Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Sunderland, Maryland 21. Sig ature of Funer | Servic License Stewart Funeral Home, Inc. 22. Name and Address of Facility 4001 Benning Road NE 20019 Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARTIKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Se wentially list conditions if any, leading to immediate cause. Enter Underlying Examine and I-transit DENERS FIA the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown isigned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 1 Inpatient 2 FR/Outpatient 3 DCA ျပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D30268

State Registrar

NOV 1 8 2010

2003

completed cause of death (Item 23a) (Type, Print)

Medical Parkway, Annapolis, 4020to

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Marylan		artment of I			giene Reg. No. 2 0 1 0	37936
	П	Registrar     Decedent's Name (First, Middle)	e, Last)			inouto or i	Journ	2. Date of De	ath	3. Time of Death
Physicia Medio		Elifine	sh Leges	e Baysa				Novembe	r 16, 2010	4:50 A. M
Examin		4a. Facility Name (if not institution, Suburban Hosp	-	nber)			r Location of Dea esda	th	4c. County of Dea	
Funeral Director		5. Social Security Number None	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. la <b>53</b>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			rthplace (State or Foreign ountry) <b>hiopia</b>
ld now	_	Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or Loc	cation			- 51	10d. Inside City Limits
arylan a-f sh ffied a	Director		gomery	100.00		r Spring				1 X Yes 2 No
the M or 28 e not	Ι	10e. Street and Number	,			10f. Zip Code			10g. Citizen of What C	ountry?
n with is 23a nust b	Funeral	11628 Stewart	Lane; Apt	304		20904			Ethiopia	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any rijury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	ried Armed Fo	2 🗶 No /e	lf	Vas Decedent of H f Yes, specify Cuba □ Yes 2 No	an, Mexican, Puer	specify Yes or No- to Rican, etc.)	Black, Whi	
72 hou	Completed	(Specify only highe	nt's Education est grade completed	-	(Give k	lent's Usual Occup kind of work done O NOT use retired)	during most of wo	orking	16b. Kind of Business	sindustry
within within giene. ler tha t, the I		Elementary/Seconday (0-12)  12th grade	College (1	-4 or 5+)	Н	lousewife			Domest	ic
l be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, L <b>Legese Bay</b>	•				18. Mother's Na <b>Berki</b>		Maiden Surname) <b>1e</b>	
2 should the and N 27 is ma		19a. Informant's Name/Relationsl Tesfaye Chumo	(Husband)	)	1	-			er, City or Town, State, Z	
t and theal item;		Abeje Chumo (So 20a. Method of Disposition			lace of Dispos	sition (Name of		Date Date	20c. Location - City of	
Page nent o		1 🔼 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				el Cemet		.22,2010	DeBerezie	t,Ethiopia
Darki permit. Departri Importa any inju		21. Signature of Funeral Service I	censee	15		. Name and Addre	ss of Facility ${f R}$	N. Hort	on Company	Morticians,
- AO		Xanna	10.7	and						ton,D.C.20011
Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	ach line.	m Orga	ın Dysfun		c or respiratory an	rest,	Approximate Interval Between Onset and Death days
Examiner	_	Sequentially list conditions,	h Act	ute Myoc	ardial	Infarct	ion.			days
uted nd ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	c. Ce:		cular	Accident				days
ate be executed only sician and the burial-transit	dical E)	resulting in death) Last		(or as a consequ ute Rena		ıfficienc	:y			days
tificate	Med	IF FEMALE:								
the death certification by the attending practice of the reseasing the standing practice of the seasing the seasin	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	1 🔲 Live	tcome of pregna Birth 2  Feta gnant at time of c nown	ıl death 3 🗀	Ectopic pregnand Other (specify)	cy		23d. Date of d Month	elivery Day Year
es that the signed by be detail	ρ	Part II. Other significant condition	ons contributing to o	leath but not res	ulting in the u	nderlying cause gi	ven in Part I.		obacco use contribute t	o the cause of death?
require been si should	etec		1. 1.					24a. Was		utopsy findings available
The law ate has I page 2 s	Completed							autor perfo	psy prior to	completion of cause of
pa ate	å	25. Was case referred to medical examiner?	Hospital:			Oth	lace of Death (Chi	eck only one)		
ician: Th	욘	1 Yes 2 X No 27. Manner of Death	1 <b>X</b> 28a. Date	Inpatient 2  of injury	ER/Outpatien 28b. Time of	nt 3 🗆 DOA	4 L Nursing		dence 6 Other (Spenow injury occurred	cify)
Physician: The this certificate ral director, pa		27. Manner of Death		nth, Day, Year)	injury	worl		Zed. Bosonbo (	iow injury coodinou	
tending Physician: The Jeath.  Tor. After this certificate the funeral director, pa		1 X Natural 5 ☐ Pendir 2 ☐ AccidentInvesti	ng (Mor gation				_			
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E Hospital or Attending Physician: The Hospital or Attending Physician: The na 24 hours affer death.  The Funeral Director: After this certificate pleted filled in by the funeral director, pa	Certificate:	1 M Natural 5 Pendir 2 Accident Investi, 3 Suicide 6 Could determ  29a. Certifier 1 Medical E (Check 2 Medical E	ng (Mor gation not be ined 28e. Place build	e of Injury - At ho ing, etc. (Specify pest of my knowl sis of examination	edge, death o	eet, factory, office	on, death occurred	and due to the ca	vn, State) use(s) and manner as s	tated.
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To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completed filled in by the funeral director, pa	Certificate:	1 Matural 2 Accident 3 Suicide 4 Homicide 6 Could determ  29a. Certifier (Check 2 Medical Eonly one) 3 Certifying 29b. Signature and title of certifier 30. Name and address of person	ggation not be 28e. Place build 28e. Pla	e of Injury - At ho ing, etc. (Specify, best of my knowl sis of examination To the best of my	edge, death on and/or invest y knowledge, d	eet, factory, office  occured at the time gigation, in my opini leath occurred at the  29c. Licens  >65  Print)	on, death occurred time, date and per number	and due to the ca at the time, date a lace, and due to th	uuse(s) and manner as s and place, and due to the le cause(s) and manner a 29d. Date signed (Mon November	tated.  cause(s) and manner stated. s stated.  th, Day, Year)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completed filled in by the funeral director, pa	Certificate:	1 Matural 5 Pendir Investion 1 Pendir Investion 2 Accident 3 Suicide 4 Homicide 6 Could determ  29a. Certifier 1 Medical Equal to Check 2 Medical Equal to Conty one) 3 Certifying 29b. Signature and title of certifier	ggation not be 28e. Place build 28e. Pla	e of Injury - At ho ing, etc. (Specify, best of my knowl sis of examination To the best of my	edge, death on and/or invest y knowledge, d	eet, factory, office  occured at the time gigation, in my opini leath occurred at the  29c. Licens  >65  Print)	on, death occurred time, date and per number	and due to the ca at the time, date a lace, and due to th	uuse(s) and manner as s and place, and due to the le cause(s) and manner a 29d. Date signed (Mon November	tated.  cause(s) and manner stated. s stated.  th, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/13/2010 Physician/ DWIGHT LEE BROOKS 1639 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CLINTON SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Hours Min. 1 1 M 2 | F Month, Day, Year) /14/1956 HALIFAX, VA Director 577-76-4440 Usual Residence of Decedent or 28a-f shov 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland Prince George's Suitland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3835 St. B<u>arnabas Road #</u> 20746 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify Completed 3 Divorced 4 Divorced BLack Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Bus Driver</u> Private traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. ပ Alexander Brooks Josephine Pannell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Brooks / Father 3835 St. Barnabas Road # 203 Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/19/2010 Alexandria, VA <u>Metropolitan</u> 21. Signature of Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. Marlboro Pike Forestville, Maryland 20747 complications that caused the death. Do not enter the mode of dying, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Die to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conquence of the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached g Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate I 1 🗆 Yes 2 🕅 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide iniury 5 Pending 1 ☐ Yes 2 ☐ No Investigation **Director:** completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29d. Date signed (Month. Day. Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ Month 10/2010 0016 WANDA HILLMAN BOWMAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 🔽 1/26/1945 Washington, DC Director 65 578-58-4519 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Maryland Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5016 Leland Drive 20745 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Stenographer Dept. of Treasury other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Page 1 and 2 should be Green Hillman Mattie Lattimore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2951 Victory Lane # 203 Suitland, Maryland 20747 Michelle Bowman / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify 11/20/2010 Laurel, Maryland Maryland National permit. Signatur of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. MOLA Marlboro Pike Forestville, Maryland 20747 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE CANCER Physician/ LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 14UMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical KIDNEY Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No 1 Yes 2 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown BLEEDING GASTRO ENTESTINAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0044957 10 2010 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 7600 Takoma Park, Maryland 20912 trol Ave. Randall Wagner 31. Date filed (Month, Day, Year) 32. Rea State

DHMH 17 Rev 7/2009

Registrar

7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per inf 9928 6-1-12 yt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ί̈́Ο, 2010 John Edward Burke November 11:50 a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Mary's C<u>allaway</u> Social Security Number . Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 Year Days **Funeral** Sex 1 X M 2 □ F Months Min. (Month, Day, Year) 02/06/1956 Hours Country) Virginia **Director** 212-68-6195 Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Marvland | Calvert North Beach 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? Funeral 23a 3693 Bedford Drive 20714 United States and Mental Hygiene. is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 XNo
If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 A Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be a Department of Health and Ments Important: If item 27 is marked Thomas J. Burke, Sr. Eileen V. Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen E. Mumford/Sister 2205 Meville Court, Waldorf, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 11/15/2010 | Charlotte Hall, MD Signature of uneral Service Edward N. Bri 22. Name and Address of Facility Signal Brinsfield Funeral Home, P.A. Brinsfield, 22955 Hollywood M00052 Road, Leonardtown, MD <u> 20650</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition mo Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of Exami that the death certificate be executed sician and burial-trans Due to (or as a consequence of resulting in death) Last physician s the burial Medical attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) \_\_\_\_\_ IE EEMALE Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No ed by the a detached f 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has by page 2 s autopsy performed? Yes 2 X No Hospital or Attending Physician: The certificate ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospice House Hospital: Other: 2 X No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗓 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury Accident
Suicide Μ Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined rlo.
in 24 hours
o the Funeral Dir
completed filler' Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 2010

DHMH 17 Rev 7/2009

Registrar

State

10) pro

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

24435 Mervell Dean Road, Hollywood, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

M.D.

1 5 2010

Youngsik Moon,

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 40 am K John /Medical 4a. Facility Name (If not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Hagerstown 5 Hage 0 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 2 🗆 F Hours 91 Director 128-40-4150 Oct. 13,1919 Bessarabia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits items 23a or 28a-f shov ner must be notified at Maryland Washington County Director Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14014 Marsh Pike Funeral er than "natural", or items 23a, the Medical Examiner must 21742 U.S.A. filed within 72 hours after death v Hygiene. vther than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No by Specify. Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5# Elementary/Secondary (0-12) s 1 and 2 should be filed w f Health and Mental Hygier item 27 Is marked other tt Chemist Leather Production Co. event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Ivan Alexandravitch Balutel 2 Eugenie Bokov Balutel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Holsten-friend 8264 Williamsport Pike Falling Waters, WV 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Rock Creek Cemetery 11-23-2010 | Washington, D.C. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, n,each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of) Examiner esquesitiony liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4Xi∪nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 5 autopsy perform certificate 1☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: No (Sec Other: 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3ELDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ome 30. Name and address of person/who completed cause of death (Item 23a). (Type,

3/4-1

State Registrar

DHMH 17 Rev 1/2001

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Brown James Aloysius Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Allegany 4b. City, Town, or Location of Death Western MD Regional Medical Center Cumberland 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 1 🔀 M 2 🗆 F Months Days Hours **Director** 220-10-7589 90 Usual Residence of Deceden or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1 X Yes 2 No ò 10e Street and Number 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country? Funeral 12 North Johnson Street 21502 USA within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1943If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Specify White 1945 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Carrier USPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Leo Patrick Brown Elizabeth Stuart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 North Johnson Street. Cumberland, MD 21502 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Geraldine E. Brown / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory : 11/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland. MD Signature of Funeral Service 22. Name and Address of Facility dams family funeral fome, 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day 2 No Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes \( 2 \sum \) No 24a. Was an has autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Certificate: To 1 🗆 Yes 2 1 No Other; 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Investigation Accident 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0054004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MRA Shiv C. Khanna, M.D. 1221-E National Highway, LaVale, MD 21502 31. Date filed (Month, Day, Yea, NOV 18 20 32. Registrar's Signature

State

Registrar

2010

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			* Kenz Leika	Physica	(n		DG9	048		11/19	10		
	13		30. Name end address of person who comple	ted cause of deeth (Ite	m 23a) (Tu	pe, Print)		06					
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	Sta Registra		31. Date filed (Month, Day, Year)	732. Registrer's Sign		akal							

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Amend 19a per FH 6910 dk

State of Maryland / Department of Health and Mental Hygiene 1 37943 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ <sup>D</sup>23.2010 6:25 pm M Belsheim Robert Oscar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heartfields at Frederick Frederick Frederick 8. Date of Birth (Month, Day, Year) Aug 26, 1924 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 D F Hours Min. Country) 579-58-2803 86 Director Iowa Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director Washington, District of Columbia D.C. None 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 20037 2475 Virginia Avenue, NW Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😿 No Specify: White Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Govt Lab Mechanical Engineer 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Belsheim Ida Kessey Gullick 0scar 19a. Informant's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Frederick Avenue, Frederick, Maryland 21701 Mr. Allen R. Belsheim, -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Smithsburg Crematory Nov 26, 2010 Smithsburg, Maryland 4 Depnation 5 Other (Specify) Signat e of Funeral Service Dicensee Keeney & Basford P.A. Funeral Home 106 E Church St, Frederick, Maryland M00706 DOLAGEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Schosis Anten Coro NM THERO ISEASE Physician Medical Due to (or as a consequence of): Examiner MEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No is after death.

al Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medica Be 26. Place of Death (Check only one, examiner? Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea. 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47951 November 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 Tollhouse Avenue, Frederick, Maryland 21701 Sibte A. Kazmi, M.D.,

15x

State Registrar 31. Date filed (Month, Day Var)

32. Regionar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 26, 2010 4:00 a M Johnson Sylvester Bright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5415 Broomes Island Road Port Republic Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, April 24, 1.XM 2 □ F Director MD 217-60-8404 56 Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Port Republic MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20676 USA 5415 Broomes Island Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify 3 Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Eliza Johnson John William Bright Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Cynthia Coates - sister P.O. Box 303, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 № Burial 2 □ Cremation 3 □ Removal from State **Brooks UMC Cemetery** December 3, 2010 St. Leonard, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home. P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to for as a cause. Enter Underlying Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s nas autopsy performe certificate | 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, is 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, MD Mathur 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			for State Registrar	Otate of Wary	•	rtificate of D		Workar Try	Reg. No.2 0   0	37946	
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	Physicia Medio		Louise M	Madeline Bohl	e			Month November	Day Year 12, 2010	10:50 P M	
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	and show	ō	10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits	
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	a or		10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?	
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	r deat		<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	12. Was Decedent Ever i Armed Forces? 1  Yes 2  No		Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White		
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E 0	Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		cemetery, crer Tr	natory or other place inity il Gardens	e) No	vember . 2010	Waldorf, M	arvland	
Baltimore,	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	ns <del>g</del> e /			s of Facility Ma	ttingley-G	ardiner Funera	1 Home, P.A.	
<u> </u>	88 = 88		Michael A.	Hardiner			P.0	. Box 270,	Leonardtown,	Maryland 20650	
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	npli tions that caused the one cause on each line.	death. Do not ente	er the mode of dying	g, such as cardia	c or respiratory an	est,	Approximate Interval Between	
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical		ysician: To the best of my kininer: On the basis of examin							
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-	Examin	ier	159 Fairfield Drive		4b. City, Town, or Fred	erick	Deam		4c. County of D	ederick
I	Funeral Director		5. Social Security Number  166-56-8243  6. Sex 1 ☒ M 2 ☐ F  45	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birth (Month, Day 1arch 2	g. 8,1965 Ma	Birthplace (State or Foreign Country) ry Land
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Baltimore, Maryland 21215-0036	Page 1 annent of Hant of Hant: If ite		1 Burial 2 X Cremation 3 Bemoval from State cemeter	ery, crem	sition (Name of patory or other place Cremator			/2010	20c. Location - City Frederic	or Town, State k, Maryland
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	İ		30. Name and address of person who completed cause of death (Item 23a) (	(Turns 12)		7931			11/9/201	.υ
	1		Dr. Kairouz, 46-B Thomas Johnson	on D	rive, Fre	ederic	k, M	D 2170	2	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37948 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:27a M Bailin 2010 Byron November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery Angel Gardens Assisted Living Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) New York 1 🗓 M 2 🗆 F Months Days Hours Min 08/30/1929 Yrs 132-20-8740 Director Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 U.S.A. 2901 S. Leisure World Blvd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or iter Armed Forces?

1 X Yes 2 No Black, White, etc. Q. 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify "natural" Completed 3 Widowed 4 Divorced Caucasian Korea the Medical 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working e 1 and 2 should be filed within 72 tof Health and Mental Hygiene.
If item 27 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meteorologist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 David Bailin (Unknown) Drapkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leisure World Blvd.. Silver Spring, MD 20906 Toby Bailin - Spouse 2901 S. 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of ē cemetery, crematory or other place Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdn's 11/15/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Speorty) 22. Name and Address of Facility Hines-Rindle Funeral Home, 21. Signature of Funda Service License MDOTO 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Progressive Debilitation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner End-Stage Parkinson's Disease Years Sequentially list conditions Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events -transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 1 Nc has this certificate 2 No 1 Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Certificate: To Be examiner? Assisted Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital 1 Yes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA Living 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

12<sup>†</sup> State

Registrar

M.D..

32. Registrar's Signatur

3331 St. Paul Street, Baltimore, Maryland 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schroeder,

Arthur Francis

NOV 1

5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37949 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 07 Physician/ 2010 7:30 pm Charles Bush Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday Funeral 1 🛛 M 2 🗆 F Months Hours Min (Month, Day, Year) South Carolina 579-42-5776 Director 76 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Silver Spring Maryland Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20904 U.S.A. 13140 Cabinwood Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Education 5+ Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked (Unobtainable) Luke Bush Lula and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh treent of Health a tant: If item 27 is Jane A. Bush - Spouse 13140 Cabinwood Drive, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite 5 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 11/17/2010 Brentwood, Maryland injury o 4 Donation 6 Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO12411800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 MONTHS Immediate Cause (Final Physician Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner <u>Ishemic Heart Disease</u> 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 should be Hupertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Renal Insufficiency certificate has autopsy page performed? death? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: မ 1 ☐ Inpatient 2 🗓 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗶 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aft d in by the fur Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of 29d. Date signed (Month, Day, Year)

104

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Ira Schneider

M.Q.,

32. Segistrar's Signature

Ereva

4061

10313 Georgia Avenue, #306, Silver Spring, MD 20902

November 08, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Arnold Samuel Brodsky OI: 6ZA M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPICE isbure Nicomice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Min. Hours 04/14/1922 216-12-8236 88 Director Yrs Belgium Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Funeral Director 10d. Inside City Limits Maryland Wicomico 1 Yes 2 No Salisbury ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5920 Tappan Lane items 23a 21801 IISA 12. Was Decedent Ever in U.S. Armed Forces?

1 K Yes 2 No If Yes, Give Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or 1 Black White etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Army "natural", Completed 3 X Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the engineer food processing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Morris Brodsky Luba Collton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie J. Brooks/daughter 5920 Tappan Lane, Salisbury, MD 21801 27 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery | 11/16/2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22 Hane and Address of Facility and Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or cord lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death LYMPHOMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** LYMPHOCYTIC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ing physician and e as the burial-transi Cause (Disease or ilniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Year Yes cate has been signed by the apage 2 should be detached in 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Yes 25. Was case referred to medica funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P143 Other (Specify) 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pendina 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Hulten

31. Date filed (Month, Day, Year)

WAR 4

2

2010

Brodsky

32. Registrar's Signature

Resura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 1:43AM 2010 Delma Geraldine Black Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince George Hospital Center Prince Georges Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Maryland 1 🗌 M 2 🕱 F Director 214-34-0200 76 May Usual Residence of Decedent f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Prince George Hyattsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 7912 14th Ave Apt # 20783 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Delma Hood William Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 1478 Hartwood Rd., Fredericksburg, VA 22406 Juanita Campos - Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Covenant Funeral
Service Crematory permit. Page 1 Department of Important; If it any injury or o 1 Burial 2 XI Cremation 3 Removal from State 11/23/2010 Fredericksburg, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1310 Courthouse Rd. 21. Signature of Funeral Service Liv Todal ND1471 Covenant Funeral Service, Stafford, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ratal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) Month Day 9 Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 은 within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury 28b. Time of 27 Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29h of certifie 29d. Date signed (Month, Day, Year) 20 9010 155230  $\nabla \nabla \nabla$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr., Cheverly, MD 20785 Terri Matin, M.D. 31. Date filed (Month, Day, Year) State NFC: Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar		artment of I		and Me	ntal Hyg	giene		
			Registrar  1. Decedent's Name (First, Midd	lle I ast)		Cer	tificate of I	Death			Reg. No.	2010	37952
	Physicia		Yaeno	ile, Lasty		Caughma	n			. Date of Dea . Month	Davi	y a Year	3. Time of Death
	Medi Examii		4a. Facility Name (if not institution	n, give street and num		,augmma	4b. City, Town, o	r Location of		ovembe		7 , 2010 County of Deat	5:00 A <sup>M</sup>
-			8830 Bluffwood	l Lane			Ft. Was					county of Dear	
Т	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>X</b> XF	7. Age (In yrs. : 80		If Under 1 Year Months Days		24 Hrs. 8.	Date of Birth	1	9. Biri	thplace (State or Foreign
	Director		212-94-7725 Usual Residence of Decedent	1 L W 2 434	00	Yrs.	Wienting Bays	Hours	0	3/31/1	930		<sup>untry)</sup> Japan
	and show	ō	10a. State 10b. Count			ty, Town or Loc	ation						10d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Princ	ce George'	s	Ft. Was	shington						1 ☐ Yes 2 <b>X</b> 🔀 No
	h the	a D	10e. Street and Number	1 T			10f. Zip Code				10g. Citiz	zen of What Co	untry?
	2 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	Funeral Director	8830 Bluffwood				20744					Japan	
(0	or dea		11. Marital Status 1 □ Never Married 2 😿 Ma	Armed Fo		S. 13. V	as Decedent of H Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)	1	4. Race - Ame	
036	rs afte ral", Exan	ed b	3 ☐ Widowed 4 ☐ Divorce	15 V O:-	e	1	☐ Yes 🗶 🕱 No	Specify:			s		sian
5-0	e filed within 72 hours after death with the Maryland ttal Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed by	15. Decede	ent's Education lest grade completed)		16a. Deced	ent's Usual Occup	ation	- ( )		16b. Kin	nd of Business	Industry
121	within 7. giene. er than t, the Me	No.	Elementary/Seconday (0-12)	College (1	-4 or 5+)	life. DO	ind of work done of NOT use retired)	auring most o	ot working				ŕ
<b>d</b> 2	filed wit al Hygie d other vent, th	Be (	12 17. Father's Name (First, Middle,	l ast)		поше	maker	40.14.11				In Ho	ome
lan	ould be fil nd Mental marked ( matic ev	ျ	Kaiichiro	Ura				Hic		rst, Middle, N Koga	1aiden Si	urname)	
ary	should I and Me		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	Address (Street	and Number	or Rural Ro		City or T	own State Zin	Code
Σ	ealth in 27		John Caughman	/ Husband			Bluffwoo						20744
ore	ge 1 and 2 should be it of Health and Men it if item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial <b>※</b> ▼ Cremation	3 Removal from	State C	Place of Dispos	ition (Name of atory or other plac		Date			ation - City or	
Baltimore, Maryland 21215-0036	tt. Pag rtmen rtant: njury		4 Donation 5 Other	Specify)	Ka	las Cre	matory	1		/2010			Maryland
Bal	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signatur francial Service	Licensee	5	22.	Name and Addres	ss of Facility	George	e P. Ka	alas	Funera	1 Home PA
			23a. Part 1. Enter the disease, o	r complications that c	aused the death	Do not enter	160 Oxon	HIII	Kd. (	Oxon H	ill,	Maryla	
20	hysician/		Immediate Cause (Final	only one cause on ea	ine.	13		9, 04011 45 00	ardiao or rec	spiratory arre-	31,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (	or a a constitu		jein	_				-	
	Examiner	Ļ.	Sequentially list conditions,	b	Anem	. 25							5
	sit d	Examiner	If any, leading to immediate cause. Enter Underlying	Due to (	or as a consequ	ence of):							
	ecute and I-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (c	or as a consequ	ence off:							
0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	,										
3760	ificate g phy as the	Medi	15.551411.5	T									
ق ×	eath certific attending p for use as	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnar	ncy	Ectopic pregnanc				23	3d. Date of deliv	very
80	deat the att	Physician/M	in the past 12 months? 1 ☐ Yes 24 No 9 ☐ Unknown	4 ☐ Pregr	ant at time of d		Other (specify)	у				Month	Day Year
Records, P.O. Box 687	iires that the des		Part II. Other significant condition	ons contributing to de	ath but not resu	ulting in the un	derlying cause gly	en in Port I		00 5:11			
S,	signe d be c	d by			Dut 1100	ating in the dif	acitying cause givi	en in racci.		1 Xye			the cause of death?
ord	e law require has been sig ge 2 should b	lete							_				
ě	The law ate has page 2	Completed							-	24a. Was an autopsy perform	/	prior to co death?	opsy findings available ompletion of cause of
			25. Was case referred to medical	1			26. Pla	ce of Death	(Check only	perform 1 Ves X	X No	1 🗌 Yes	2 🗆 No
Vital	hysic his ce I direc	욛	examiner? 1 ☐ Yes 2xxxNo	Hospital:	npatient 2 🗆 t	R/Outpatient	Othe	P*			nce 6 [	Other (Specifi	iv)
ַס	Ing P	ate:	27. Manner of Death	28a. Date o (Month	f injury n, Day, Year)	28b. Time of injury	28c. Injury work?	at	28d.	Describe hov			
SIO	death death ctor: /	Certificate	2 Accident Investig	not be	of Indiana Addison	- for-		Yes 2 No	_				
Division of	al or A s after I Dire		4 ☐ Homicide determ	ined building	of Injury - At hor g, etc. <i>(Specify)</i>	ne, rarm, stree	г, тастогу, опісе		28f. I	Location <i>(Stre</i> C <i>ity</i> or Town,	eet and N State)	lumber or Rura	l Route Number,
_	or the hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	edical	29a. Certifier 1XXCertifying	Physician: To the be	st of my knowle	dge, death oc	cured at the time,	date and pla	ice, and due	e to the cause	e(s) and r	manner as state	ed.
	the H	Σ	only one) 3 Certifying	Nurse Practioner: To	s of examination	and/or investig	ation in my opinior	death occur	irrad at tha t	ima data and	-less		(-) 1
	0 1 with 00 Cor		29b. Signature and title of certifier	11			29c. License	number			d. Date s	signed (Month,	Day, Year)
		-					041				11/	17/10	)
	5		30. Name and address of person v	a) [till	Rel 1	4/02	Felto:	n Ande	erson	MD L	MO	20	744
	State Registra	_	NOV 1 9 2010	Acres 32. Reg	gistra s Signat	arks!							

DHMH 17 Rev 7/2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 3795 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		C	ertifica	ate of l	Death	7			Re	g. No.		
Physicia		Decedent's Name (First, Mide	dle,Last)							2	. Date of Death Month	Day Yea	.,	3. Time of Death
Medical Exami	ner	ANTONIA MAI	E CHAMBER	RS						_ [_	November	16, 2010	31	1232 hrs
		4a. Facility Name (if not instituti 3386 Curtis Drive #20	-	iumber)			. City, To Suitlar		Location of	f Death	·	4c. County Prince (		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birt	nday)	If Under	r 1 Yea	r If Under	r 24Hrs.	8. Date of Birth	(MM/DD/YYY)		hplace (State or
Director		011-44-8446	1 M 2X F	58		Yrs.	Months	Day	s Hours	Min.	07/09/	1952	Foreig Co	n untry) MA
è	ŀ	Usual Residence of Decedent  10a. State 10b. County	,	10c. Ci	tv. Town	or Location	1							10d. Inside City Limits
and show an	'n		ce Georges		uitla									1 Yes 2 X No
the Maryl a or 28a-1 iifted at o	Director	10e. Street and Number 3366 Curtis I	Drive #204	, <del>,</del>			10f. Zip ( 20	Code 1746			10	g. Citizen of W	nat Cour	ntry?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examingt must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was De Armed I 1 Yes	ecedent Ever in Forces? 2 X No		If Yes	, specify	Cuban	, Mexican,		cify Yes or No- can, etc.)		e, etc.	can Indian, Black,
after	by F		vorced If Yes, Give Ye or Dates:			]	-		specify:			Specify:		lack
nours	ӯ	15. Decedent's Education (Spo							ion (Give k DO NOT u			16b. Kind of Bu	isiness/li	ndustry
6 727172 H	ete	Elementary/Secondary (0-12)	,	(1-4 or 5+)		ŭ					,	Real 1	Foto	to
003 within iene.	Completed		3yrs.		Pro	opert	у ма							
filed Hyg		17. Father's Name (First, Middle						- 1		,		aiden Surname	)	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Be	Antonio Shapae		-	1406	Moiling A	ddrocc	/Stree			Chamber	S Der, City or Tow	n Stato	Zin Codo)
D 2 shoul	٩	Porscha Chambe		-D+*		_		,			dorf, N		602	Zip Code)
e, MD and 2 sho Health and item 27 is traumati		20a. Method of Disposition		206	. Place o	f Disposition	on (Name				Date	20c. Location		Town, State
MOF Pages lent of lint: If		1 X Burial 2 Crematio 4 Donation 5 Other S				age C		ery		11-2	7-2010	Waldo	rf,	MD.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingry or other traumante event, the Med	ı	21. Signature of Funeral Service		Pard	,	22. Nar Mar	ne and A	Address I—M	of Facility arch	Fune	ral Hor	ne of M	ary1	and
	-1	23a. Fart I. Enter the disease, o	mplications that	raused the dea	th Do no	1 430	8 Su	iit1	and R	Rd.	Suitlar espiratory arre	nd, MD.	20 <u>7</u>	46 Approximate Interval
Physician /Medical	- 1	failure. List only one cause	e on each line.									ot, 0110011, 07 110		Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)		iac Arr		ia du	e to	Ca	rdiac	Dis	ease		_	Deau
tops of		Sequentially list conditions,	b	a consequence	01).									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		a consequence	of):									
ansit		events resulting in death) Last	Due to (or as	a consequence	of):									
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76C	Ne l	IF FEMALE:		outcome of pre	egnancy			م ا	Ectopic			23d. Date of		
OX 68 Path certif	Physician	past 12 months?  1 Yes 2 No 9 ✓ Un	4 Preg	nant at time of			death (Speci		Ectobic	pregnanc		Month	L	Day Year
the de ched :	된	Part II. Other significant condi	1 - (_)		resulting	in the unc	erivina d	cause o	iven in Par	t I.	23e. Did tob	acco use contr	ibute to	the cause of death?
P.C ss that gened to decide the	٥	Anomalous	•		-		, ,				1 Yes	2 No 3	Prob	ably 4 🗸 Unknown
ds, equir	Completed										24a. Was a	n 24b. \	Vere au	topsy findings available
COF law r has b	힘										autops perform	ned?	teath?	ompletion of cause of
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cian:	a	25. Was case referred to medical examiner?	Heenitel: -		7				of Death (				do:	0
F Vi	P	1 Yes 2 No		Inpatient 2		tpatient 3			v at Work?			Residence 6 v		: Scene
on on anding I the function	Certification:	27. Manner of Death  1 X Natural 5 Pen	28a. Date (Mont	h, Day,Year)	200. 1	ime of Inju	ry Z		'es 2 🔲 l	- 1	od. Describe in	ow injury occurr	eu	
isic Atter	<u>[</u>		estigation 28e. Plac	ce of Injury - At	home, fa	rm, street,	factory,	office b	uilding, etc	. 28	Bf. Location (St	reet and Numb	er or Ru	ral Route Number, City
Div ital or ral after			old not be ermined (Specify)	)					-		or Town, St	ate)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director.	Medical C	29a. Certifier 1 Certifying P	Physician: To the be aminer:On the basis	of examination										
To wit	Mě	29b. Signature and title of certifi	and manner : er	stated.			29c.	License	e number			29d. Date sign	ed (Moi	nth, Day, Year)
		1100	11 -K	1		7		0.C.	И.E. (	DOME		November	18, 20	)10
	-	30. Name and ad ress of persor	n with completed cau	se f death (It	m 23a)	14).			2000					
2		Theodore M. King, Jr.	., MD. Assist	ant Medical	Exami		11 Per	nn Str	eet, Balt	timore,	MD 21201			
St Regist		31. Date filed (Month, Day, Year)	32. R	egistr 's Sign	W. K.									

		For	State of	Marylan				nd Mental H	ygien	e	
		State Registrar	4)		Cer	tificate of L	Death		Reg. N	No 2 1	0 3/954
Physicia Medic			zetta F.		3					<sup>1</sup> /3, 201	3. Time of Death 19:10 M
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Funeral Director			Sex 1 □ M 2 🛣 F	Age (In yrs. la 73		If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, L		) (	Birthplace (State or Foreign Country) Outh Carolina
and show l at	or	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Maryli 28a-f	Director	Maryland Prince	George			Upper	Mar1	boro			1 ⊠ Yes 2 □ No
h the		10e. Street and Number				10f. Zip Code			10g. C	Citizen of What	
ath wil	Funeral	614 Pearse La	12. Was Decede	ant Ever in 119	S 13 V	Vas Decedent of Hi	207	/4 n? (Specify Yes or No	<u> </u>		d States
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	es? ! 🖪 No	31	Yes, specify Cuba	n, Mexican,	Puerto Rican, etc.)	)- -	Black, WI	nerican Indian, hite, etc. 1ack
natur finatur dical	olete	15. Decedent's (Specify only highest of	Education		16a. Deced	ent's Usual Occup	ation	of working	16b.	Kind of Busine	ss Industry
hin 72 ne. <b>than</b> '	Completed	Elementary/Seconday (0-12)	College (1-4	or 5+)	life. Do	O NOT use retired)	Ü	n working			
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be filed lental Hyg rked oth ic event	ျှ		rrison D	ixon			TO, WIGHTER	Snola H	•	,	
2 should th and M 27 is mar traumati		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address (Street a		or Rural Route Numb	per, City o	or Town, State,	
and 2 s Health tem 27 ther tra		Cynthia L. Chile	s - Daugl			earse La	ne Ur	per Marl	oro,	, Maryla	and 20774
Page 1 a ment of H tant: If ite ury or oth		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec				sition (Name of natory or other plac tage	<sup>e)</sup> No	vember 22 2010		Location - City Waldorf	or Town, State  Maryland
permit. Bepartm Departm Importa any inju		21. Signature of Funeral Service Licer	towar	t, 777	~	Name and Addres		Stewart E ad NE Was		cal Home gton, Do	•
FILL		23a. P . Enter the disease, or cor shock, or heart failure. List only	nplications that cau	sed the death line.	h. Do not ente	r the mode of dying	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition resulting in death)				Arrhyth	mia				Onset and Death
Medical Examiner		resulting in death)		as a consequ	,						
	ner	Sequentially list conditions, litary, reacing to mineral actions cause. Enter Underlying	ν. –	re Dis					_		
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ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or	as a consequ	uence of):						
ate be ohysic the bu	dical		d								
aath certifica attending pl	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar	ncy					23d. Date of c	dolivon
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi.	Completed by Physician/Me	in the past 12 months?  1 Yes 2 ANo 9 Unknown		th 2  Feta nt at time of d vn		Ectopic pregnance Other (specify)	У			Month	Day Year
es that tigned b	oy P	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
requires been sig should b	ted	Stroke						_   1□	Yes 2	2 🔀 No 3 🗆	Probably 4 \( \square\) Unknown
law rehas be	nple	Diabetes Mellitu	ıs					24a. Wa:	opsy	prior to	autopsy findings available o completion of cause of
sician; The la certificate ha irector, page 2								per 1 🗆 Yes	formed?	death'	es 2 □ No
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y Phys er this eral dii	<u>م</u>	27. Manner of Death	28a. Date of	injury	ER/Outpatient 28b. Time of	28c. Injury	4 □ Nurs	ing Home 5 X Res 28d. Describe			ecify)
tending death. tor: After the funer	icat	1 X Natural 5 Pending 2 Accident Investigation	on	Day, Year)	injury	M 1 🗆	? Yes 2□N	0	·		
al or Atte s after de il Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of	Injury - At hor etc. (Specify)	me, farm, stre )	et, factory, office		28f. Location City or To			ural Route Number,
To the Hospital or At within 24 hours after or To the Funeral Directompleted filled in by	Medical	(Check 2 Medical Exam	niner: On the basis	of examination	and/or investi	gation, in my <mark>opi</mark> nio	n, death occu	ace, and due to the curred at the time, date and place, and due to t	and place	e, and due to the	e cause(s) and manner stated
To t with To tl		29b. Signature of title of certifier		M	.D.	29c. License D6	number 6658			ate signed <i>(Mor</i> ember 1)	
2 1	İ	30. Name and address of person who	completed cause of	of death (Item	23a) (Type, Pr	int)					-
- +		Rexford Babilah				kway Gr	eenbe]	lt, Maryla	ind	20770	
Stat Registra	<b>-</b>	31. Date filed (Month, Day, Year) NOV 2 2 2010	32. Regi	ars Signati	ure						
7/00	20	MUN & E LUIV A		-4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 10, 2010 Year 8:20 р м **Edward Coates** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 24 Hrs. Hours Min. 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Davs (Month, Day, Year) Director 83 December 7, 1926 577-36-3675 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No MD Calvert Huntingtown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a USA 3735 Hunting Creek Road 20639 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 ğ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural". Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Alice Chase Charles Coates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3735 Hunting Creek Road, Huntingtown, MD 20639 Deborah Stepney - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Patuxent UMC Cemetery November 20, 2010 Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Sent cemia Priysician/ disease or condition resulting in death) Medical a consequence of) Goat hight lype Extremely Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi resulting in death) Last Due to (or as a consequence of) the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vllen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 0 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death.

Director: After to in by the funera injury 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RW 5 State

To the within 2 To the F

Registrar

only one) 29b. Signature a

Richard

31. Date filed (Month, Day,

certifie

Pahne

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328

32. Registrar Signature

Jowthen

00055120

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ November Day 1, 2010 Coleman Jr. Wijliam 17:06Pm Clarence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Takoma Park **Examiner** 4c. County of Death
Montgomery Hospital Washington Adventist Social Security Number last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Month Day 1 🗓 M 2 🗆 F 227-50-4177 940 Lynchburg, Director Usual Residence of Decedent or 28a-f show notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Exminer must be notified at 10a. State 10c. City, Town or Location Columbia 10d. Inside City Limits Director Howard MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21046 USA 9733 Softwater Way 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. þ 1 Never Married 2 Married X Yes 2 □ No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) City of Lynchburg Sheriff's Department Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Sheriff 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ter:na Elizabeth Davis Clarence W. Coleman Sr. 19a. Informant's Name/Relationship (Type, Print) Daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felicia Coleman-Watson 9733 Softwater Way Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Forest Hill Park 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20/2010 Lynchburg, VA 4 Donation 5 Other (Specify) Signature f Funeral Service Licensee 20019 22. Name and Address of Facility 5635 Eads St. NE Washington, DQ Dunn&Sons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 1 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident
☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Universey RLUD 31. Date filed (Month, Day, Year) NOV 1 5 2010 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2257M William Robert Cole Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Many 14050, Clistan la 5. Social Security Number 6. Ses If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) 931 Washington 1 🛣M 2 🗆 F 78 Yrs Director 579-40-7592 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Charles Waldorf MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11893 Homestead 20601 Ρĺ Α 12. Was Decedent Ever in U.S.
Armed Forces?
1 № Yes 2 □ No 1950If Yes, Give
Year or Dates. 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyWhite Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Musician and Mental Hygie is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever 2 MArgaret Albright Burton E. Cole Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Cole/Daughter 10th st North Beach MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-18-2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Cemetery 22. Name and Address of Facilitin Ronald Taylor II Funeral Hm 21. Signature of Funeral Service Lice 10583 Middleport In Plains Mp 2005 White Perf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Atheros denti Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or linjury Examine Due to for an electrosqueries on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed? death? Yes 2 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 12 R 3+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/

State Registrar 32. Registra 's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:40 PM Emmett Edward Carbonara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laure 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 □ F Months Days Hours Aufgont 1. 7 ay, 1931 Pefiffsvlvania 79 579-40-0977 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a, State 10h. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Beltsville Maryland Prince George's 1 Yes 2 No 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? Funeral 20705 United States 11216 Cedar Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than traumatic event, the Me Elementary/Seconday (9-12) College (1-4 or 5+) Hygiene. Government Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Yerrella with and Mental h permit. Page 1 and 2 should be file Department of Health and Mental Filmportant: If item 27 is marked o any injury or other traumatic eve once. Antonio Carbonara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11216 Cedar Lane Beltsville, Maryland 20705 Dolores Carbonara -wife 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 11/24/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatyra of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Cardio - Pulmonar Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner espirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical I Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day g Unknown this certificate has been signed by rail director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Nodules 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 XNo 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗶 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D60936 November 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Rd. Laurel, MD 20707 Laurel Regional Hospital State Registrar

DK.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 2010 5:15P ANTHONY С. COAD SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12405 KING HEATHER COURT PRINCE GEORGE'S MITCHELLVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 X M 2 □ F Months Hours Min oCT. 22 1958 WASHINGTON, DC **Director** 579-86-9825 Usual Residence of Decedent or 28a-f show 10a. State 10c. City. Town or Location 10d, Inside City Limits 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 No MITCHELLVILLE PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20721 USA 12405 KING HEATHER COURT or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black White etc þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 X No Specify. Specify "natural", Completed 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha PRIVATE OFFICE MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ ETHEL ARDELL GARNETT LEROY WALTER COAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12405 KING HEATHER COURT MITCHELLVILLE, MARYLAND ANTHONY COAD JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State BRENTWOOD, MARYLAND FT. LINCOLN CEMETERY 11/22/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL ROME, INC. . Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter ungeriving -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 ☐ Yes 2 🗓 No After this certificate I funeral director, page 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 XNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 은 After this 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) NOVEMBER 16, 2010 D35596 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

DHMH 17 Rev 7/2009

State

Registrar

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GEORGE

Date filed (Month, Day,

NOV 1 7 2010

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M.D

110 IRVING STREET N.W. WASHINGTON, DC 20032

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Movember SUSIE M. CHAPMAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE"S DOCTORS HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2 🛣 F Hours 9/29/1928 Yrs. Director 579-44-6225 82 Mary Tand Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director XX Yes 2 No Upper Marlboro Maryland Prince George's 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 9100 Lincoln Ave. 20772 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: **Black** 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cafateria Manager P.G. County Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Forbes Susie Savoy 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Chapman / Son 8759 Flowering Dogwood Lane Lorton, VA 22079 or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/20/2010 Clinton, Maryland 21. Signal re of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. NO1083 5538 Marlboro Pike Forestville, Maryland 20747 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Erfter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratory disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last netastatic Breast burial-transit and Due to (or as a consequence of): attending physician for use as the burial Renal Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Ectopic pregnancy igned by the atter be detached for i Live Birth 2 L ⊢eτal deal Pregnant at time of death Day Month Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy perform death? 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \sum Yes 2 \sum No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

GR State

DHMH 17 Rev 7/2009

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

11/14/10

Lonham

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		-	Registrar  1. Decedent's Name (First, Middle, Last)	·	Cer	uncate or	Deam	2. Date of D	Reg. No	0. /	<del>J 3</del>	1951
	Physicia Medic	al	Lawrence	merritt.	Cook			Month	e13	e-20,20	16	of Death
	Examin	er	4a. Facility Name (If not institution, give stree	et and number)		1	or Location of Dea	th )	40	C. County of De	ath Carl	_
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hr		irth	9. B	irthplace (Stat	e or Foreign
	Director		427-84-3132 1 N Usual Residence of Decedent	12□F 66	Yrs.	Months Days	Hours Mir	04/23/	1944	Vi	ou <i>ntry)</i> rginia	
	yland f sho	tor	10a. State 10b. County	10c. City	, Town or Loc	eation						City Limits
	Mar 28a- notifie	Direc	Maryland St. Mary's	Holly	ywood	Line To Day						Yes 2 X No
	ith th	Funeral Director				10f. Zip Code 20636			1	itizen of What C	-	
	ems (	-une		Was Decedent Ever in U.S		Vas Decedent of I	Hispanic Origin? (\$	Specify Yes or No		ted Sta		···
9	fter de , or if	by	1 Never Married 2 Married	Armed Forces? 1   Yes 2 □ No If Yes, Give		Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		Black, Wh		
8	ours a tural' al Ex	ted	3 A Widowed 4 Divorced	Year or Dates.					$\perp$	-	White	
15	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	(Give I	ent's Usual Occu ind of work done O NOT use retired	during most of wo	orking	16b. F	Kind of Busines	s Industry	
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nd	should be filed within 72 and Mental Hygiene. is marked other than ' aumatic event, the Me		17. Father's Name (First, Middle, Last)	-			18. Mother's Na	ame (First, Middle	, Maiden	Sumame)		
yla	should be file and Mental b is marked o raumatic eve	2	Gaither Cornelius Co				Betty 0	. Pipes				
Maryland 21215-0036	2 short th and ?7 is n traun		19a. Informant's Name/Relationship (Type, F	Print)			and Number or F		-			2
	F Heal		Troy H. Cooke/Son  20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name of	Mill Ro	Date Date	7	ocation - City o	21742 or Town, State	
<u>B</u>	Page 1 nent of int: If i		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	emetery, cren	atory or other pla	Cem. 11/					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	nedella	22	. Name and Addre	ess of Facility Br	insfiel	d Fur	neral H	ome, P	
			23a. Part 1. Enter the disease, or complicat	L403 ions that caused the death			.1ywood R			itown, i	MD 200	
	Physician/		shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	ause on each line.	0						Interval E Onset ar	
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68760	tificat ng ph as th	Mec	IF FEMALE:					-				
9 X	tth cer ttendi or use		23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnan	death 3		су		1	23d. Date of d Month	elivery Day	Year
Box	ie dea r the a	ysic		4 U Pregnant at time of de 9 Unknown	eath 5∟	Other (specify) _			ļ	WOTH	Day	real
P.O.	that th	Ž P	Part II. Other significant conditions contrib	outing to death but not resu	ılting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco	use contribute t	to the cause o	f death?
JS,	puires an sign uld be	edb						1 🗆	Yes 2	□ No 3	Probably 4	Unknown
Records,	aw rec as bee 2 sho	plet						24a. Was	s an Opsy	24b. Were a	utopsy finding	s available
Re	The la	Con							ormed?	death?	es 2 No	
of Vital	ician: sertific ector,	Be	25. Was case referred to medical examiner?	nital:		Oth	Place of Death (Ch	eck only one)				
) f V	Phys	2	T Yes 2 IZANO	1 Inpatient 2 ☐ E	R/Outpatien 28b. Time of	t 3 DOA	4 ☐ Nursing	Home 5 Res			cify)	-
o uc	nding ath. :: After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	wor	k? Yes 2 □ No	Zod. Describe	now injur	y occurred		
Division	r Atter	ertifi	3 Suicide 6 Could not be	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office				d Number or R	u <i>ral R</i> oute Nu	mber,
Ö	ital or urs aft ral Dir lled in	aC						City or To				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate:	(Check 2 L Medical Examiner:	n: To the best of my knowle On the basis of examination actioner: To the best of my	and/or invest	gation, in my opini	ion, death occurred	I at the time, date	and place	e, and due to the	cause(s) and	manner stated
	vithi Voithi Com		29b. Signature and the of certifier	71,		29c. Licens	e number			ite signed (Mon		
	.0-		ON Name and all the Control of the C	/ / 4 L	000\ 7 :	W 3	7070		NO	ve mber	27010	20/0
10	Me		30. Name and address of person who compl	L, war hi	44	T+ 1	1997/1	Hospi	fal			
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	park						
חח	Registra MH 17 Rev 7/20		NOV 2 3 20	IN Jeneur	P. 19	paux						
ᄱ	VIII I / MEV //20	UJ	and with the		-							

DHM

**Physici** /Medic Examin

**Funeral** Director

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	For State Registrar		-	ertificate of		Reg.	2010	37962		
cian	1 Decedent's Name (First, Middle, Las Marie Louise Cha					2. Date of Death November	Day 14, 20	3. Time of Death 12:00P. M		
dical iner	4a. Facility Name (If not institution, give	· ·			or Location of Death		4c. County of De	ath gomery		
al	Social Security Number 6. S		(In yrs. last birthd	ay) If Under 1 Yea	If Under 24 Hrs.	8. Date of Birth Feb. 26, 1		irthplace (State or Foreign		
or	220-60-0818 1 Usual Residence of Decedent	□ W 2 X	88 Yrs	5.		reb.26,1	922 Cn	ina		
ō	10a. State   10b. County   Virginia   Fairfax		10c. City, Town or McLean	r Location				10d. Inside City Limits 1 ☐ Yes 2 No		
irect	10e. Street and Number		TOLCUIT	10f. Zip Code		10g	. Citizen of What C			
Funeral Director	8370 Greensboro Di			22102			nited Sta			
2	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ender Armed Forces? 1 □Yes 2 ☑ Note of the State of	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - An Black, Wh Specify:			
leted	15. Decedent's Ed (Specify only highest gra	de completed)	(G	ecedent's Usual Occ	upation a during most of work ed)	ing 168	b. Kind of Busines	s/Industry		
Completed	Elementary/Secondary (0-12)	College (1-40-5+		cher	90)		ducation			
To Be (	17. Father's Name (First, Middle, Last) Tao-An Hua				18. Mother's Nam Ming-Feng	e (First, Middle, Mai g Mao	den Surname)			
	19a. Informant's Name/Relationship (George C.F. Chang		100000		t and Number or Rui			, Zip Code) inia 22 <b>1</b> 02		
	20a. Method of Disposition  12 Burial 2 Cremetion 3 4 Donetion 5 Other (Specific	Removal from State	20b. Place of Di cemetery,	sposition (Name of crematory or other pl Heaven Ce	ace)	Date 200	c. Location - City of			
i i	21. Signature of Funeral Service Licen		_	Donald V. 4400 Powde	Borgwardt er Mill Ro	Funeral ad Beltsv	Home, PA	ryland 20705		
ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Alzheimer's Disease  Due to (or as a consequence of):    Dementia									
Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome o  1  Live birth 2  4  Pregnant at 9  Unknown	Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)	ncy		23d. Date of d Month	elivery Day Year		
ed by Pł	Part II. Other significant conditions of Hypertension; Dep		not resulting in th	e underlying cause ç	iven in Part I.		37	to the cause of death?  Probably 4  Unknown		
Complet						24a. Was an autopsy performer	d? I death?	autopsy findings available occupletion of cause of		
	25. Was case referred to medical examiner?	Hospital:			1	h (Check onty one)				
Medical Certification: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day,	t 2 ☐ ER/Outpa / 28b. Tim /Ye <i>ar)</i> Inju	e of 28c. Inj	4 LI Nursing Ho	ome 5 ☐ Residence 28d. Describe how		sajsted Lvng		
Sertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Location (Stree City or Town, S	et and Number or ( State)	Rural Route Number,		
edical (	29a. Certifier (Check only one)  1	nysician: To the best of niner: On the basis of and manner state	examination and/c	eath occurred at the or investigation, in my	time, date and place	, and due to the cau	se(s) and manner and place, and d	as stated. ue to the cause(s)		
Me	29b. Signature and title of certified	m J.	Ninal		nse number 5285		. Date signed (Mo.			
	30. Name and address of person who Wilkinson Ninala, 31. Date filed (Month, Day, Year)	M.D. 344	Universi	ty Blvd.,	J.,#113 Si	lver Spri	ng, Mary	land 20901		
tate trar	31. Date filed (Month, Lay, Teal)	JZ. negistral	Signature	borres						

DHMH 17 Rev 1/2001

Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day MART. COCHRAN 2010 7:16 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 31, 1927 6. Sex **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛂 F Days Hours Min. Director 208-18-6527 83 Yrs. May Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a State 10b. County illed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 K Yes 2 No MD Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21716 USA 2 Manchester Court . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ Carl Farkas Ruth Hinnershotz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 2 Manchester Court, Brunswick, MD 21716 Nora Wilson-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ٥ 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 11/16/2010 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick,MD 21702 23a. Part 1. Enter the disease shock, or heart failure. Li or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the IE FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Year Day signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 Yes 2 No Be 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ၉ 1 Inpatient 2 K ER/Outpatient 3 I DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft
completed filled in by the fu ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 32. Regist ar's Signature

Green

610 Ninth Ave

Brunswick, MD 21716

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flemina

Christopher

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Carolyn Anne Chavez 2010 5:00 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital <u>Silver Spring</u> 7. Age (In yrs. last birthday) **Funeral** g. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 🖾 F Months Oct. 27 1948 Washington, Hours Min. Director 219-56-1165 62 Yrs. DC Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Funeral Director 10d. Inside City Limits 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 14112 Grand Pre Road #22 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced <sup>Specify:</sup> Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress/Cashier Food Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Uknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 14112 Grand Pre Road #22, Silver Spring, MD <u>April Cohoon, Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 21. Signature of Funera Service Licensee M01294 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non Small Cell Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonitis Wks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Yrs. Due to (or as a consequence of): Physician/Medical certificate be attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Recent AKA of Left leg for gangrene, Type 2 Diabetes Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Mellitus, Morbid Obesity 24a. Was an performed Yes 2 2 XNo 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ ✓Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending Natural Natural injury 2 Accident
3 Suicide
4 Homicide I hours after death uneral Director: / Investigation 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) the 29c. License number Superich RSM MD 11/05/2010 D 0065 485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) file 1500 Forest Glen Rd. Silver Spring, MD 20910 Barbara Supanich

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

of Vital

Division

15 2010

10-09086 John Wade Colenda

## Amend Item 21 per FH G910 12/2/10 dk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death November 27, 2010 Medical Examiner 0409 hrs John Wade Colenda 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 501 South Union Avenue Havre de Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Delaware Days Min Months Hours 214-63-7968 Director 8 Jan. 31, 2002 1 X M 2 F Yrs Usual Residence of Decedent any 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show Perryville s 23a or 28a-f shove notified at once. Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sht or other trannatic event, the Medical Examiner must be notified at once. rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21903 35 Jackson Station Road ۵ 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 1 Yes Specify: White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify. ğ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed Perryville Elementary during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Three Years Student Perryville, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname John Allen Colenda Jennifer Dennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Jackson Station Rd., Perryville, MD 21903 19a. Informant's Name/Relationship (Type, Print ) John A. Colenda (father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Principio Cemetery 12/01/10 Perryville, Maryland 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr. per DVR

222. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P
Perryville, Maryland 21903-0766

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

App Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Meningoencephalitis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Lyme's Disease Sequentially list conditions, Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a,b,27 per me g912 2-14-11 vt by the attending physician ached for use as the burial -X UNPENDED Box 68760, IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 Fetal death Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? o. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown ۵. Completed Records, certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 X Natural Division 1 Yes 2 No the Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 27, 2010 Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signatur State

Registrar

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended item#17, WCHD, SLU Certificate of Death, 1. Decedent's Name (First, Middle, Last) 3. Time of Death of Death Physician/ Virginia Smith Month Culp  $\mathbf{a}^{\mathsf{M}}$ November 2010 1:43 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 309 Park Heights Ave. Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 ื F Days Hours 97 08/03/1913 214-32-0734 Maryland Director Yrs. Usual Residence of Decedent 28a-f shov 10a, State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Park Heights Ave. 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) secretary clerical Be 17. Father's Name (First, Middle, Last) Samuel Clarence Hitch 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ပ -Samuel Clarence Smith Virgie Jones 19a. Informant's Name/Relationship (Type, Print) 1 and 2 show of Health and item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Culp/spouse 309 Park Heights Ave., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Wiccinico Memorial Park 1 🛚 Burial 2 🗌 Cremation 3 🗌 Removal from State 11/11/2010 4 Donation 5 Other (Specify) Salisbury, MD Signature of Funeral Service Licensee Professional Association Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) End Stage Dementia Medical Due to (or as a consequence of Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami Cause (Disease or linjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autonsy performed? death? 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 🗌 Yes 욘 4 Nursing Home 5 X Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death.

To the Funeral Director: All completed filled in by the fu ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nursa Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Mont

HUY

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ /2010 STEPHANIE Y. DUNN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Capitol Heights Prince George's 7003 Rose Quartz Terrace 8. Date of Birth (Month, Pay, Year 1/16/1971 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗌 M 2 🕱 F 39 Director 579-96-1096 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a or 28a-f sho any hijury or other traumatic event, the Medical Examiner must be notified at any hijury or other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No Maryland Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code by Funeral 7003 Rose Quartz Terrace 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 21 No Baltimore, Maryland 21215-0036 1 Yes 2x No Specify: Specify: Black If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Government Budget Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ James Thomas Dunn Michele Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1438 Ames Place NE Washington, DC 20002 Michele Dunn / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Crecity) 11/19/2010 | Brentwood, Maryland Lincoln 22. Name and Address of FacilityPope Funeral Homes, P.A. . Signature of Funeral Service 5538 Marlboro Pike Forestville, Maryland 20747 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Aspry Onset and Death Physician/ Medical xintland disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed and-tran Due to (or as a consequence of) physician a the burial-1 Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown signed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? after death.

Director: After this certificate has Yes 2x X No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be filled in by the funeral director, examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 14cmg 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Hospital or Attending 1 Natural
2 Accident
3 Suicide injury 08 work 5 Pending hersel 1 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7003 Rose Quartz errace, Capt. Heights, Md 4 Homicide determined bome 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/13 Pa 2010 Physician/ Nancy Fitzwater Diggs 1:17 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Hospice of the Chesapeake Harwood Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours Min 66 0370871944 215-44-7775 Director MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Prince Georges Glenn Dale 1 ☐ Yes 2X☐ No MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 20769 U.S.A. 12505 Ransom Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive VP of Philantropy Easter Seals Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Nadine Marie Hardesty Charles Ernest Fitzwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12505 Ransom Court, Glenn Dale, MD 20769 James F. Diggs, Sr./Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial Gd 11/17/2010 Dunkirk, MD Signature\_of Funeral Service License 22. Name and Address of Facility Lee Funeral Home Calvert, 8125 Southern MD Blvd., Owings, MD 20736 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 X No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 2 No should be detached 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has perform this certificate 1 🗌 Yes Yes 2[ within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ပု Yes 2  $\square$  No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Immer of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) 5  $\square$  Pending Natural work' Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 052830 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 10 . Registra s Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Juanita Davis 6:55A M NOVEMBE 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Community Hospital Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8 Date of Birth **Funeral** 1 □ M 2**X** F Months Days Hours 07/12/1933 Director 237-52-4233 77 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director r 28a-f sh notified 1 X Yes 2 No MD Prince Georges Landover 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? þe Funeral ral", or items 23a Examiner must b 1211 Consideration Lane 20785 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify 3 ¥ Widowed 4 □ Divorced Specify: Black Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Hitem 27 is marked of မ ont of Health and Menta it: If item 27 is marked y or other traumatic ev Octavis Hewlin Birder Ruth Silver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Consideration Lane Landover, MD 20722 Patricia Hughes/ Daughter 20a. Method of Disposition
1 💆 Burial 2 🗆 Cremation 3 🗔 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 11/20/2010 | Brentwood, MD 21. Signature of Jun val Service bicenede 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Respiratory Failure Medical Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Congestive Heart Failure Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for Dav Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was ... autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the Certificate: 28c. Injury at work? 1 🕅 Naturai 5 Pending injury Accident 1 Tes 2 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7207 HANOVER State Registrar

Juson,

DAUES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ner-I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dixon Robert Stephen Sr. 2010 :50 a.m Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22909 Cedar Lane Road St. Mary's Leonardtown Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 🕅 M 2 🗆 F (Month, Day, Year) 03/15/1926 Director 84 214**-**28-4078 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 22909 Cedar Lane Road 20650 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Il Hygiene. other than "natural", If Yes, Give Specify Specify: 3 X Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Field Engineer <u>Telephone</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H is marked o 2 permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other Raymond Johns Dixon Mary Serena Fish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia I. Dixon/Daughter 22909 Cedar Lane Road, Leonardtown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion United
Methodist Cemetery 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/22/2010 Mechanicsville, MD Signature of Meral Service I 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease 30 <u>vrs</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number NW18, 2010 3 pm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. 1Bux 527 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

State Registrar Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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1 - State Registrar	amend #29b ter Mary and Bepart Por Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 1 0									
Decedent's Name (First, Middle, Last)     Rosa Elena Calderon De Ga	rois			Date of Death     Month		3. Time of Death				
Medical		Als City Town or	Leastien of Dooth	Novembe	r 17, 2010					
Examiner 43. Facility Name (if not institution, give street and number, 13154 Greensburg Road	,		Location of Death hsburg		4c. County of Dea					
Funeral 5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	thplace (State or Foreign				
Director 611-39-5578	97 Yrs.			Jan. 25	, 1913 EI	Salvador				
Pue 5 pp 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits				
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F Miguel Calderon				ia Lima	raideri Surriame)					
99 0 to to to to to to to to to to to to to	19b. Maili	ing Address (Street a	and Number or Rura	al Route Number,	City or Town, State, Zi	ip Code)				
Marina Garcia Suggs – dau					urg, Maryl					
Designation of the page of the	20b. Place of Disponente	matory or other place	e) •		20c. Location - City or Santa Ana.	Town, State El Salvador				
21. Signature of Funeral Service (Specify)	, a balance of a cities (apacity)									
21. Signature of Funeral Service Chensel	Jame J. Juliu 415 E. Wilson Blvd., Hagerstown, Md. 21740									
	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoek, or heart failure. List only one cause on each line.  Approximate Interval Between									
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23b. Was decedent pregnant in the past 12 worths?	h 2 🗆 Fetal death 3	23d. Date of de Month	elivery Day Year							
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Sompleted by CHRONC OBSTRUCTIVE				24a. Was ar autops perform	y prior to	utopsy findings available completion of cause of				
e		26 Pla	ace of Death (Checi	1	No 1 ☐ Ye	s 2 No				
25. Was case referred to medical examiner?  1 Yes 2 No Hospital:  1 Inpart	atient 2 ☐ ER/Outpatie	Othe	ar-		nce 6 Other (Spec	cify)				
27. Manner of Death 28a. Date of in (Month, L	njury 28b. Time o Day, Year) injury	work's	at ?	28d. Describe ho						
28a. Date of in the part of th	Injury - At home, farm, str		Yes 2 □ No	28f Location (Str	reat and Number or Pi	umi Pouta Number				
4 ☐ Homicide determined 286. Place of 1	etc. (Specify)	cot, lactory, office		City or Town	Street and Number or Rural Route Number, wn, State)					
Whithing A the footing physician: To the post table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table to the footing physician: To the past table	fexamination and/or inves	stigation, in my opinio	n, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated.				
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105 3/3 L	3	058			NOVEMBER	19,2010				
30. Name and address of person who completed cause of 12916 Concurrent Dr. Suite 31. Date filed (Month, Day, Year)			EN BLAS		November	19, 2010				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2338P M 2010 Robert Delgado Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11 M 11 alispur Peninsula Regional Medical Center 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number **Funeral** 1 X M 2 □ F Months Hours April Day O'ear 1946 C#NY fornia 64 Director 556-60-375<u>4</u> Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 □ No Pittsville MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a USA 21850 35190 Old Ocean City Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Forces's 1 Never Married 2 X Married 1 Tyes 2 No "natural", or þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Saudi Completed 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) U R L Financial Advisor Financia1 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ္ Luisa Morales Rau Delgado 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22485 Stevenson Drive, King George, VA <u>Joyce Delgado</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State 11.15.2010 Frankford, DE Cape Henlopen Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 21. Signature of Funeral Service Lie 108 William St. Berlin, MD 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between LEUKEMIA ROLYMPHOC Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Due to (or as a con quence of): Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) -transit The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death the detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Registrar
DHMH 17 Rev 7/2009

30. Name and address of person

Jimmy

ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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State Registrar

Denve S. parked

Chestertown, MD.

6602 Church Hill Rd.

32. Registrar's Signature

Is Mena Criv 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Rachel Arena

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Pate of Death 3. Time of Death Physician/ November 10:45 am Shirlev Lorraine Dwyer Medical 4b. City, Town, or Location of Death Lanham 4c. County of Death Prince George's 4a. Facility Name (if not institution, give street and number) **Examiner** Doctors Community Hospital . Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Dec. 18ay, 1933 WasHington, DC 76 579-42-4194 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Prince George's Greenbelt 1 A Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 United States Funeral 10A Crescent Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>8</u> ☐ Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University of Maryland Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle, Last) ျှ Mary Bell Davis Raymond Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7105 Westwind Drive Bowie, Maryland 20715 Thomas Rice Dwyer, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 11/23/2010 Brentwood, Maryland 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service License Nan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final respirator-Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes Inpatient 2 ER/Outpatient 3 DOA ပ္ 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Natural Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 | only one) 29b. Signature and title of certifie 21/2010 6061 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Day Month Physician/ 1818 Edelen OTh 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore of Maryland Medical university 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** Months 5 - 1 2 - 1 9 55 55 Director 14-68-9888 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 本Yes 2 □ No 28a-f Bryantown Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral 20617 6000 Roosevelt Place USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: Specify: If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farming Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eversity in the contraction of the contraction ဂ္ Thompson Catherine Edelen Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6000Roosevelt Pl.Bryantown MD\_20617 <u>Joyce Edelen/Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/16/10 Alexandria Va Metropolitan Aguasco Ka 22. Name and Address of Facility
Adams Funeral 21. Signature of Funeral Service Licensee MD 20008 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final Anoxia Physician/ disease or condition resulting in death) nours Medical Due to (or as a consequence of): **Examiner** Fallure Kespira Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit Hepatic Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Alcohol Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Other (specify) been signed by the a should be detached 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy performe death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မှ 1 Tes 2 **X**No After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 24 hours after death. Funeral Director: A Investigation Accident the ' 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 10 1922331784 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RR

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>2010 Physician/ John Langford Eubank, Jr. Month 6:40 AM M Nov. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 452 West South Street Apt. 2 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹M 2 □ F Days Hours July 18, 1950 220-50-7221 60 Mary land Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director notified Maryland Frederick Frederick 1X Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 21701 U.S.A. 452 West South Street, Apt. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force 1 ☐ Yes 2 🏋 No If Yes, Give \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Chef injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o John Langford Eubank, Sr. Rose Pauline Myers permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mai any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9715 Amber Gate Court, Gaithersburg, MD 20882 Dehiana R. Eubank, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State St. Johns Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. 2, 2010 Frederick, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licen Keeney and Bastord PA Funeral Home M00255 East Church St.. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition belomina 00-01-00006 mo Medical resulting in death) Examiner cholongeo carecinon Sequentially list conditions, if any leading to in record cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examine attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🐼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗌 No 1 Tes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 욘 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier W1 56 Forder 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ CATHERINE **ETUH** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De **Examiner** DOCTORS HOSPITAL LANHAM Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F **Funeral** 1 M 2 T Months Days Hours 212-27-0802 76 Director Usual Residence of Decedent or 28a-f show be notified at 10b. County 10a. State 10c. City. Town or Location death with the Maryland Director PRINCE GEORGE'S MD RIVERDALE 10f. Zip Code 10e. Street and Number ıral", or items 23a o Examiner must be Funeral 6829 RIVERDALE ROAD #C202 20737 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 11. Marital Status If Yes, specify Cuban, Mexican, Pue Completed by 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 within 72 hours after Catherive 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 ▼ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12TH <u>ENTREPRENUER</u> t of Health and Mental Hygi If item 27 is marked othe or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's N ၉ Page 1 and 2 should be CHARLES ETUH CATHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 6829 RIVERDALE ROAD CAROLINE ETUH/DAUGHTER 20a. Method of Disposition Place of Disposition (Name of emetery, crematory or other place) Burial 2 Cremation ō Department of Important: If any injury or 12/ Donation 5 Dother (Specify) ₹AMILY PLOT Signature of F and Service Licensee 22. Name and Address of Facility 13 7474 LANDOVER ROA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Se Immediate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, he ling to immediate cause. Enter Underlying Cause (Disease or iinjury Exami the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Lo attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by certificate has page within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (C Be examiner? Hospital Other: 2 1 No 2 ER/Outpatient 3 DOA 4 Nursing မ 1 Inpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and

3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	24a. Was an autopsy findings available prior to completion of cause of								
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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 Physician/ Month Year Lois Deane Emmett Vovembrei Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Hospital Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Oct. 15 Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Days Hours 74 Yrs Director 409-58-9457 936 Tennessee Usual Residence of Decedent show 10a, State 10b. County with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f MD 0555 Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 199 Rollins Ave #506 20852 United States death 0 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 6 þ 1 Never Married 2 Married Yes 2 No 11/5/10 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Specify: Caucasian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Il Hygiene. within 7 College (1-4 or 5+) Elementary/Seconday (0-12) 12 Waitress Food Industry Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of 0 Page 1 and 2 should be nent of Health and Ments 107 traumatic Jesse Jake Goforth Ella Elizabeth Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 William Andrew Emmett, Son 600 East Gude Drive, Rockville, MD 20852 zwet Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ō 1 Burial 2 X Cremation 3 Removal from State Department Important: If any injury or once. Ft Lincoln Crematory 11/15/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) M01294 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breast Physician/ metastatio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Litter onderlying Cause (Disease or iinjury Due to (or as a consequence of) y physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ast attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has te performed' After this certificate 2 1 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 HNo Other: 1 Tes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d, Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation neral Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Prestjoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sile Davar Rockville, mD MD Suite 204 10110 molecular Dr. 1

0555 AM

1 X Yes 2 ☐ No

Year

20850

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

rech

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		C	ertificate c	of Death			giorio	Dog No		
Physic Medical Exar			dle,Last)						2. Date of De			3. Time of Death
Medical Exal	mne	LAWRENCE C. T	OSTER						Month Novemb	Day er 11, 2010	Year )	0537 hrs
		4a. Facility Name (if not instituti 10850 Indian Head H		umber)		4b. City, Town		of Death			nty of Dea	
Funera		5. Social Security Number	6. Sex			Fort Was					e Georg	
Directo					. last birthday)	If Under 1 \	Year If Under Days Hours	Min.	8. Date of E	irth(MM/DD/Y)	YYY) 9. B	irthplace (State or
	•	578-64-1696 Usual Residence of Decedent	1 X M 2 F	62	Yr.	S.	ays Hours	IVIII I.	6/18/	1948	C	<sup>ign</sup> Washingto ountry)
Iny	Ĺ	10a. State 10b. County		Inc. Cit	ty, Town or Loca	tion						
id how				l l	y, rown or Loca	lion						10d. Inside City Limi
ne Maryland or 28a-f show any fied at once.	15	Maryland Princ	e George'	s Fo	rt Wash	ington						1 Yes 2 N
he Ma or 28	l ë	10050 T- 11	1			10f. Zip Code	Э			10g. Citizen of	What Cou	intry?
with the s 23a s 23a	1 2	10850 Indian H		ay # 21		207				USA		
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. **Red other than "natural", or items 23a or 28a-f shoen, the Medical Examiner must be notified at once.	Funeral Director	1 X Never Married 2 M	arried Armed Fo	orces?		as Decedent of es, specify Cub	Hîspanic Origi oan, Mexican,	in? (Spec	cify Yes or Ne		ace - Amer	rican Indian, Black,
fter d	I E	3 Widowed 4 Div	orced If Yes, Give Yea	2 No					, 5.5.7		riite, etc.	
ours a atura	P P	45 David # 51	or Determ		16a, Deceder	Yes 2 X		ind of	4. 4	Specif		ack
72 h 12 h	Completed	Elementary/Secondary (0-12)	College (1		during m	ost of working li	ife. DO NOT u	use retired	k done i)	16b. Kind of	Business/	Industry
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5-0 lied v lied v Tothe	၂ ပိ	17. Father's Name (First, Middle,	Last)		240 .	) I I V C I	18.Mother's	Name (F	irst. Middle.	Metr Maiden Suman	ne)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	James L. Fost								kander	,	
D 2 shoul nnd M 'is m	ပ	19a. Informant's Name/Relations			19b. Mailing	Address (Str	eet and Numb	er or Rur	al Route Nur	nber, City or To	own, State	, Zip Code)
imore, MD ; Pages I and 2 shoument of Health and Ptant: If item 27 is no or other traumatic		Patricia Alforo	d / Mother		10850	) Indiar	n Head	High	way Fo	ort Was	hing	ton, Md 744
Baltimore, Normit, Pages I and Department of Healti Important: If item nijury or other trau	11.0	1 Burial 2 Cremation	3 Removal fro	m State 20b.	Place of Disposi crematory or oth	tion (Name of c	emetery,		ate	20c. Location	n - City or	
Baltimo permit, Page Department of Important:	1 1	4 Donation 5 Other So	ecify:	M:			,,	11/1	7/201/	61 1.		
Salt ermit epart mpor rjury		21. Signature of Funeral Service	Licensee	1100	aryland 18/	ame and Addre	ss of Facility	11/1	Funore	1 Chelt	enhar	n, Maryland
	UL 2	Charles E. 1		-	553	8 Marlb	oro Pi	ke F	oresta	rillo '	S, P.	A. Land 20747
Physician /Medica		23a. Part I. Enter the disease, or failure. List only one cause	complications that can on each line.	used the death	. Do not enter th	e mode of dying	, such as can	diac or re	spiratory arre	est, shock, or h	neart	Approximate Interval
Examiner	1	Immediate Cause (Final disease	a. Complication	ns of Chror	nic Alcoholisi	n						Between Onset and Death
		or condition resulting in death)	Due to (or as a	consequence o	f):							
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	oncoguones o	n.							
	miner	cause. Enter Underlying Cause (Disease or injury that initiated	C.	onsequence o	1).						25,	
ed risit	Exar	events resulting in death) Last	Due to (or as a c	onsequence o	f):							
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760, cate be ex physician he burial	edical	UNPENDED	AMENDED									
Sox 68760, death certificate be executed to aftending physician and I for use as the bunal - transi	3	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou	tcome of pregr	nancy					23d. Date o	of delivery	
x 6 h cert tendir use a	cia	past 12 months?	I LIVE DIT	nt at time of dea	ath		Ectopic pr	regnancy		Month	Da	ay Year
- 0 = 8	Physicia	1 Yes 2 No 9 Unkn			5 Othe	er (Specify)						
<b>~</b> □ ≈ □		Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the un	derlying cause	given in Part I		23e. Did tob	acco use conti	ribute to th	ne cause of death?
- 83 00 U	<b>9</b>	Hypertensive atherosc	lerotic cardiovas	scular disea	ase			ĺ				bly 4 Unknown
rds requirements	Completed							_	24a. Was ar			ppsy findings available
eco ne lav te has ge 2 s	틹							-	autops perform	y   1	prior to condeath?	mpletion of cause of
n: Ti		25. Was case referred to medical							1 <b>✓</b> Yes 2		Yes	2 No
/ita	o Be	examiner?	Hospital:	atient 2			of Death (Ch					
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	$\vdash$ $\vdash$	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatient : 28b. Time of Inju			ursing Ho		esidence 6		Scene
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r Attender death irector:	<u>[g</u>	2 Accident Investig	pation	f Injury - At hor	me, farm, street,							
Div spital or ours after neral Dir filled in	<b>=</b>	3 Suicide 6 Could r 4 Homicide determi		injury ~ At nor	ne, iarm, street,	ractory, office b	uilding, etc.	28f.	Location (Str or Town, Sta	eet and Numberte)	er or Rura	Route Number, City
Hosp 24 hos Fune tely fi	ᄓ	On Codifica		F my knowled -	4			- 1				
Division of Vital Rec To the Hospital or Attending Physician: The J within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	( ) I	2 Medical Exami	sician: To the best of ner:On the basis of e	Adminiation and	d/or investigation	at the time, da , in my opinion,	te and place, death occum	and due t ed at the f	o the cause(	s) and manner	as stated	
E 3 E 3	Medic	9b. Signature and title of certifier	and manner state	ed.		29c. License						
		- 1/6				O.C.N				29d. Date signe		
OCME	3	0. Name and address of person wh	o completed cause of	if death (Item 3	(3a)	3.0.1				November	11, 201	J
- 4			eputy Chief Me		•	enn Street,	Baltimore	. MD 21	1201			
Sta	te 3	Date filed (Month, Day, Year)						,				
Registr	ar	NOV 1 7 2010	known &	. Again	the							
11MIL 47 D- 4 1000	4	•										

10-09009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sheila Louise Farrell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Month Day November 23, 2010 Sheila Louise Farrell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St Mary's Hospital Leonardtown St. Mary's 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Director Months 214-82-9807 Davs 52 1 M 2K F September 9,1958 Virginia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. St. Mary's Maryland 1 Yes 2 No Chaptico Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25502 Budds Creek Road 20621 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 3 Widowed 4 X Divorced If Yes, Give Year is marked other than "natural"; 1 Yes 2 X No specify: ģ Specify.White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) United States Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. College (1-4 or 5+) Waste Water Operator 12 Government 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Raymond Elzear Chainay Be Ruth Faunce 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 25502 Budds Creek Road Chaptico, Maryland Ruth Elisa Farrell / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) November 30. 4 Donation 5 Other Specify: Charles Memorial Gardens 2010 Leonardtown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. laroliner P.O. Box 270 Leonardtown, Maryland 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. /Medical Between Onset and Immediate Cause (Final disease Fentanyl intoxication ≵xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and ed for use as the burial - tran Physician/Medical X UNPENDED 27,28a-f, per ME G910 12.13.10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ

2126 hrs

Death

Year

29d. Date signed (Month, Day, Year)

November 24, 2010

The law requires that the death certificate be executed Records, of Vital Division

this

After

29b Signature and title of certifie

Laron Locke MD.

31. Date filed (Month, Day, Year)

NOV 29

Certens

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other **✓** Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural Pending Fd 11/23/10 Fd 8:30 pm 1 Yes 2 X No unk Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number City or Town, State) 25502 Budds Creek Rd Chaptico, MD 6 X Could not be determined (Specify) Found: residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCMF 2006

State

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 25 per med cert 6910. T27217 follows Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Virginia Fazenbaker November 16 2010 Physician/ Lillian 11:15 PM Medical c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westernport Moran Manor Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Feb. 3 1919 1 M 2 XF Days Hours Maryland 219-14-6906 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director MD Garrett Bloomington 1X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 327 North Branch Ave. United States Funeral 21523 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 9 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: permit. Page 1 and 2 should be filed within 72 hours aftre Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examenee. 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Housework Elementary/Seconday (0-12) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Allen **Russell** Pattison Eva 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 279 Gemanell Ave, Bloomington, Maryland 21523 Louise Mills/ niece cemetery, crematory or other place)
Cumberland Crematory 11/17/2010 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Cumberland Maryland 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 21562 7. W 4220 111 Church St, Westernport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Phytician/ horon Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? in 24 hours after death.

the Funeral Director. After this certificate hapleted filled in by the funeral director, page 1 🗌 Yes 2 🗌 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 0 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harshad Bokil, 566 South Mineral St, Keyser, W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 rack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Joseph Ferger Jr. <u>2</u>010 November Medical 10:30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6185 Belgrave Court Salisbury Wicomico 5. Social Security Number 6. Sex 1 M 2 F **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min. Director 219-32-3635 74 Hours 0572671936 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6185 Belgrave Court 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 K Married 1 X Yes 2 □ No If Yes, Give AirForce Year or Dates AirForce þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) engineer drafter AT + T Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Joseph Ferger Sr. Mattie V. Gladden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon K. Ferger/spouse 6185 Belgrave Court, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation, 3 🗆 Removal from State 11/15/2010 Donation 5 Other Specify Baltimore, MD Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Th Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between n each lir nediate Cause (Final Onset and Death Physician/ do dues lestic ROLD & MALT disease or condition MUDICAMA Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in neciate cause. Enter Underlying Examine Due to (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Unknown signed by the at d be detached for Dav Year Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s after death.

I Director: After this certificate has page 2 s autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 \( \subseteq \text{Yes} \) 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) townr-1 11/10/10

Registrar

State

E CAROLI STRUT,

Solisbury, MD. 2189

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32.

egistrar's Signatu

Day Year)

10-08690		Please Type or Print in Black Indelible	lnk.	Ensur	e All Cop	ies Are L	.egil	ole.		
Marie Lynn Fong	eal	1- For State Certificate			d Mental	Hygiene		201	9	37983
Physicia		Decedent's Name (First, Middle,Last)				2. Date of D	Reg. i Death Da			3. Time of Death
Medical Examin	ıer	Marie Lynn Fongeallaz  4a. Facility Name (if not institution, give street and number)	Ab Cit	y Town or	Location of Dea	Novem	ber 12	2, 2010 4c. County o		2147 hrs
		291 E. Pulaski Hwy Rm 301		ton	Ecoalion of Dec	201		Cecil	i Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		nder 1 Year		lrs. 8. Date of	Birth (A	MM/DD/YYYY)	g. Birth Foreign	place (State or
Director		144-60-9845 1 M 2 F 47 Y	rs.	July Duy	1		16,	1963	Cour	
v any		10a. State 10b. County 10c. City, Town or Loc	ation							10d. Inside City Limits
yland -f shov	tor	MD Cecil Elkton	1.00							1 X Yes 2 No
vith the Maryland 5.23a or 28a-f show a	Director	168 W. Main St.		Zip Code .921				Citizen of Wha	at Counti	ry?
n with t	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	as Dece	edent of His	panic Origin? ( , Mexican, Puer					an Indian, Black,
		1 Yes 2 X No	_	2 X No		to Rican, etc.)		White,		
ours aft atural' xamine	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedential 16a. Deced	ent's Usu	ial Occupati	on (Give kind o		16	Specify: b. Kind of Bus	Wh i	
36 in 72 h han "n Iical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		3	DO NOT use re	etired)				
5-00; ed with tygiene other t	ا ق	11 Homem 17. Father's Name (First, Middle, Last)	aker		8.Mother's Nar	ne (First, Middle	e, Maid	Own H en Surname)	ome	
21215-0036 uld be filed within 7 Mental Hygiene arked other than c event, the Medica	8	John Hawkins			inda G					
MD 2 d 2 shoul lth and M n 27 is m aumatic	의				and Number of				, State, Z	Zip Code)
re, N 1 and F Health f item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State crematory or or	sition (N	lame of cen		Date 1/23/20		c. Location - (	City or To	own, State
Baltimore, permit. Pages I a Departament of the Important: If the		4 Donation 5 Other Specify: R.T. Foat		•	- 1		- 1	ising S	Sun,	MD
Balt permit Depart Impor injury		21. Signature of Funeral Service Licenses 22. R	Name a	<sup>nd Address</sup> Foard	of Facility Funeral St. El	Home,	P.4	A		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each light.	the mod	e of dying,	such as cardiac	or respiratory	arrest, s	shock, or hear	t T	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a Combined alcohol an	d qu	e <b>tia</b> p	ine int	oxicat	Lon			Between Onset and Death
		Due to (or as a consequence of):  Sequentially list conditions,  b								
	ine	If any lineding to immediate Due to for as a nonsequence or cause. Enter Underlying Cause								
cuted	Examin	events resulting in death) Last  Due to (or as a consequence of):								
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760, icate be physic the bun	Med	AMENDED 23a, 27, 28a-f per  IF FEMALE: 23b. Was decedent pregnant in the	ME 2	910 I	<u>2/22/10</u>	TT	2	23d. Date of de	elivery	
Box 68760, death certificate be the attending physic of for use as the burner	sician/Medic	past 12 months? 2 F	etal deat ther (S		_Ectopic pregr	nancy	1	Month	Day	y Year
the deat y the at shed for	≥L	1 Yes 2 No 9 ✓ Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the			and in Dark I	Loo- Bid	101 000			
P.C	[≦	combung to death but not resulting in the	undenyi	ng cause gr	ven in Part I.			No 3		e cause of death?
v requir	) ete					24a. Wa	s an opsy			osy findings available
Division of Vital Records, tal or Attending Physician: The law require is after death.  Director: After this certificate has been sited in by the funeral director, page 2 should the street or the street of the street or the st	Completed						formed	? dea	eth?  Yes	2 No
irector,	8	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatier			of Death (Check		7 n		0	
of V ng Phy	I	1 ✓ Yes 2 No 1 Inpatient 2 ER/Outpatier  27. Manner of Death 28a. Date of Injury (Month, Day, Year)  4 No 1 Inpatient 2 ER/Outpatier  28b. Time of (Month, Day, Year)		28c. Injury				dence 6 🗸		cene
Sion vitendii death. ctor: /	atio	Natural 5 Pending Fd 11/12/10 Fd 9:4		4	es 2X No	unk				
Divis	Certification	3 Suicide 6 Could not be determined Specify House	et, facto	ry, office bu	ilding, etc.	28f. Location	(Street State)	and Number	or Bural MD	Route Number, City aski Hwy
Division of With Hospital or Attending Plywithin 24 hours after death. To the Funeral Director: After roompletely filled in by the funeral actions.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	rred at ti	ne time, date	e and place, and	d due to the car	use(s) a	and manner as	s stated.	
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.  29b. Signature and title of certifier		ny opinion,		at the time, dat				
	-	Ward-outs Della 10		O.C.M				I. Date signed ovember 10		
	-	30. Name and address of person who completed cause of death (Item 23a)								
Stat					timore, MD	21201				
Stat Registra	~	DEC 0 2 2010 Server B.	aks							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend#1. PerPhys. PGC11-24-10cm Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -AKA John Carroll Gillum 12:34 JOHN CARROLL CILLUMS 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE VA MEDICAL CENTER BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min Director 723-09-2613 01/28/1928 Wash, D.C. Usual Residence of Decedent show 10a. State 10h County should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md Prince George's Hyattsville 10e. Street and Number 10g. Citizen of What Country? Funeral 4907 Eastern Avenue # 208 20782 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 

X Yes 2 □ No
If Yes, Give
Year or Dates.

No
45-47 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Law Enforcement Elementary/Seconday (0-12) College (1-4 or 5+) 12th Police Officer P.G.Co. Police Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Gillum Floree Pyles mol.,
if. Page 1 and 2 shour.
if Page 1 and 8 shour.
if Yealth and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ira Gillum/Son 1221 M St., N.W. # 533, Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 5 1 XBurial 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) Maryland Vets. Cem. 12/01/10 Cheltenham Maryland Signature of Funeral Service License 22. Name and Address of Facility
Henry S. Washi
4925 Burroughs ngton <u>A</u>ve auc & Sons Co. Inc. N.E. Washington D.C 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician CARDIOPULMONARY APPEST Medical resulting in death) Due to (or as a consequence of) Examiner 1 YEAR CANCER METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 XNo Other ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury work?
1 Yes 2 No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours 1 Mcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the pasts of examination and three against and grant of the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29c. License number Dante P25582 7+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SUEFREDINI MO911 SU

31. Date filed (Month, Day, Year)
NOV 2 2 2010

BALTIMORE, MD.

UTH CHARLES STREET APT #207

32. Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State	of Maryla	-	artment of F		nd Men		ne No:2 0   1	27005	
П	Dharisi		1. Decedent's Name (First, Middle	e, Last)						Date of Death Month	Day Year	3. Time of Death	
	Physici /Medic		Eddie Gilc	hrist, Sr	· .						04,2010	12:17 A. <sup>M</sup>	
	Examin		4a. Facility Name (If not institution		*		4b. City, Town, or				4c. County of Dea		
			Heartland Hea	1th Care			e Hyat	tsvil		Date of Birth	Prince G		
	Funeral Director		5. Social Security Number 577–14–9010	1 <b>½</b> M 2 □ F		s. la <i>st birthd</i> ay) Yrs.	Months Days		Min.	Date of Birth Month, Day, Ye		thplace (State or Foreign ountry)	
_			Usual Residence of Decedent		94					/07/191	b MCC	ormick,S.C.	
	rylan show	_	10a. State 10b. County		10c. 0	City, Town or Lo						10d. Inside City Limits	
	Ba-f s	Director	D.C.	Washington								1 X Yes 2 No	
	hours after death with the Maryland tural", or items 23a or 28a-f show I Examiner must be notified at	Ö	10e. Street and Number	<b>a</b> =			10f. Zip Code			10g.	Citizen of What Co		
	eath v	Funeral	122 18th St.		cedent Ever in	IIS 13	200 Was Decedent of H		in? (Specify	Ves or No-	U.S.A		
	fter d	Fun	1 ☐ Never Married 2 ☐ Marr	Armed F ried 1 ☐ Yes	Forces?		Was Decedent of H If Yes, specify Cuba		Puerto Rica	n, etc.)	Black, Whi	te, etc.	
5-0036	al', o	by	3 ☐ Vidowed 4 ☐ Divorced	If Yes. G	aive		1⊡ Yes 2⊡ <b>x</b> No	Specify:			Specify:	Black	
ڻ ا	be filed within 72 hours after death with the Marylar at all tygiene. An all Hygiene. An all then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Deceden (Specify only higher	t's Education st grade completed	()	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most o	of working	16	b. Kind of Business	/Industry	
2	/ithin ne. han "	ם	Elementary/Secondary (0-12)		(1-4or 5+)				3		. G . G		
7	filed within 72 h I Hygiene. other than "natuent, the Medica	ပိ	12th 17. Father's Name (First, Middle,	l ast)		Tru	ck Driver		's Name <i>(Fir</i>	st, Middle, Mai	O.C. Gove	rnment	
and	d be f ental R ced of	Be c	Robert Gilchr	•					ah Gar		den damame,		
$\leq$	2 should and Men is marke aumatic	2	19a. Informant's Name/Relations			19b. Maili	ng Address (Street			Route Number, City or Town, State, Zip Code)			
Z Z	and 2 ealth a n 27 is er trau		Dorothy M. Bau	m/Daughte	er	5804	Annapoli	s Rd.	# 100	7,Blade	ensburg, M	d. 20710	
č.	of ite		20a. Method of Disposition	0 DD	20b	. Place of Dispo	osition (Name of matory or other place	ce)	Date	200	c. Location - City or	Town, State	
Ĕ	Z # 6 0		1  Burial 2  □ Cremation 4  □ Donation 5  □ Other (S		n State	ashingt	on Nat'l.	Cem.	11/16	/10   8	Suitland,		
Baltimore,	permit. I Departm Importal any Inju		21. Signature of Funeral Service	Licensee		2:	2. Name and Addre	ss of Facility	hinato	n & Sor	ns Co.,In	C.	
"	20 E # 9		Yany	04.	nau	4	925 Burro	oughs A	Ave.,N	.E., Was	shington,	D.C. 20019	
			23a. Part1. Inter the dis a se, or shock, or heart failure. List	complications that only one cause on	each line.		ter the mode of dyin	ng, such as c	cardiac or res	spiratory arrest	,	Approximate Interval Between Onset and Death	
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ca	raco		aton 1	1008	B+				
	Examiner			Due to	o (or as a conse	equence of):	16. 6	Lanis	lant				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Attranscionation  b. Camon Casculor Accident  Due to (or as a consequence of):  Attranscionation  Conditions  Divisionation  Divis										
	od d ansit	Examiner	that initiated events	AH	14NSCO	works	Corde	20100	soul	y Dr	Seaso		
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3/60	ate be hysici	lical		d//	yper	tense	(2)						
õ ×	death certifica attending ph	Physician/Med	IF FEMALE:	20- 16	/_ /								
gox	death o e attend ed for us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	utcome pf preg birth 2 ☐ Fe	tal death 3	Ectopic pregnancy	/			23d. Date of de Month	livery Day Year	
j.	the de y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk	gnant at time o nown	rdeath 5L	Other (specify) _						
ŗ.	w requires that the de been signed by the should be detached		Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.		23e. Did tobac	co use contribute t	o the cause of death?	
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<del>ပြ</del>	s beel	lete	Mascullar	· Dan	nont	<u> </u>			11	24a. Was an	24b. Were a	utopsy findings available	
r	و ع ق	E O	Hymal	Sumin	amia	2	<u> </u>			autopsy performe	d? ✓ prior to	completion of cause of	
<u> </u>	sician: Th certificate rector, pag	BeC	25. Was case referred to medica					26. Place o		1□ Yes 2 <b>□</b> neck only one)	PNO ILLITE:	s 2□No	
or <	ē. ē. ₹	P.	examiner? 1 ☐ Yes 2 🗗 No	Hospital: 1	Inpatient 2	□ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nurs	sing Home	5 🗆 Residenc	e 6 Other (Spe	ecify)	
	ng ifter		27. Manner of Death 1 ■ Natural 5 □ Pendin		e of Injury onth, Day Year)	28b. Time o Injury	Wor			Describe how	injury occurred		
<u> </u>	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	gation				Yes 2 □ N			7000		
UIVISION	or At after d Direct in by	ij	4 Homicide determ	ined 20e. Plac	ding, etc. (Spe		reet, factory, office		28f. I	Location (Stree City or Town, S	et and Number or F State)	ural Route Number,	
_	spital ours a neral filled		29a. Certifier 1 Certifyir	ng Physician: To the	ne best of my k	nowledge, deat	h occurred at the tii	me date and	t place, and	due to the caus	se(s) and manner a	s stated	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical one)	Examiner: On the	basis of exami inner stated.	nation and/or in	vestigation, in my o	pinion, death	th occurred a	t the time, date	and place, and du	e to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifie	r			29c. Licens	e number	-	29d.	. Date signed (Mon	th, Day, Year)	
6	11		A A PA	10			4	1867	/	1	1/10/10		
	207		30 Name and address of person	who completed car	use of death (It	em 23a) (Type,	Print)			/	1 1.15	20852.	
	K		Uncy Zuni	30. 4	Pagistrania Si	andol	ou fec v	+ 216.	z ROC	CKUEC	.4. MA	ausz.	
7	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 2010	Deneva	Registrar's Sig	alle							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Bonnie Kaye Gill 201 605 AM Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Prince Georges ľakoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) V<u>irginia</u> Days Jan 24 1 M 2 X Hours 52 17958 Director 212-66-7964 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director Md. Prince Georges 1 Yes 2 XNo Hyattsville 23a or 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4310 Jefferson St. U.S.A. #104 20785 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. , Or þ 1 X Never Married 2 Married ☐ Yes 2 ☐**X**No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Household College (1-4 or 5+) 1 + Elementary/Seconday (0-12) Homemaker any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F. Melbalene Lowery Carl Fredrick Gill Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitzi Nickle – sister 2952 Colebrook La.,Lake Ridge,Va. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 2010 1 Burial 2 Ferenation 3 Removal from State Department Important: It Beltsville Chesapeake Crem. Nov 16, 4 Donation 5 Other (Specify) Signature of Funeral Service nsee 22. Name and Address of FacilityEternal Faith Funeral Svc. 20746 M01576 5625 Allentown Rd., Camp Springs, Md. 23a. Part 1. Enter the disease, o shock, or heart failurg. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should peen 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has performed? certificate 1 🗆 Yes 2 10 this certificaral director, p 25. Was case referred to medice **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 110 မ Inpatient 2 ER/Outpatient 3 DOA 27. Manne eath 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 일 29c, License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year State NOV 1 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day ELOISE GARNER 2010 11 6:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE NURSING HOME CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours 1 □ M 2 😾 F 577-32-5501 83 WASHINGTON, DC Director Yrs 1927 JUNE Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Examiner must be notified Yes 2 No MD PRINCE GEORGE'S CLINTON 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7711 CASTLE ROCK DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 'natural", or 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify BLACK Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER GOVERNMENT Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy, Important: If item 27 is marker any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ALPHONZO LACEY NELLIE GRIFFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORENZO GARNER/HUSBAND 7711 CASTLE ROCK DRIVE CLINTON, MARYLAND 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEME. 11/19/2010 CLINTON, MARYLAND J. B. JENKINS FUNERAL HOME, INC. 21. Signature of 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of) Examiner COLON CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 🛚 No 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 X No 1 ☐ Yes 2 🛛 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? iniury 1 X Natural 5 Pending 2 No 2 Accident
3 Suicide Investigation completed filled in by the Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Hospital Medical 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartilying Number and number of the cause of an analysis of the cause of the ca (Check 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D35206 NOVEMBER 15, 2010

Statu Registrar

DHMH 17 Rev 7/2009

11701 LIVINGSTON ROAD #101 FT. WASHINGTON, MARYLAND 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM TANNER M.D.

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #8 Per INF G916 6/07/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Novembe 1:08 Dallas Edward Goldsmith PM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Plata La 5. Social Security Number If Unde Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Yea **03** r 12 Country) Maryland 1 🖳 M 2 🗆 F Hours Min Director 220-32-5520 75 December Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Mary1and Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5968 Goode Road 20637 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Groundman Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dallas Samuel Goldsmith Mary Eleanor Canter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Robert S. Goldsmith, Sr./brother 7335 Oliver Shop Rd., Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Nurial 2 Cremation 3 Removal from State Dld Fields Cemetery 11/20/2010 Hughesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. S unat re of Funeral Service License 22. Name and Address of Facility Prinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Multisystem Ph\_sician/ disease or condition resulting in death) ms Medical Due to (or as a consequence of): Examiner undrome avaneoplastu Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month 2 🗌 No Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24 hours after death.

• Funeral Director; After this certificate has been six feted filled in by the funeral director; page 2 should be 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound to the second the second to (Check Medical Examines. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Murge Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signature a 29d. Date signed (Month. Day, Year) D46419 ress of person who completed cause of death (Item 23a) (Type, Print) 10ml GAFRETT AUC LAPLATA Md. 20146 31. Date filed (Month, Day, Year) State NOV 1 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine Lucille Goldbach 4:30 P.M November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 25, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💆 F Months Hours Country) Maryland 216-28-0751 Director 77 1933 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No St. Mary's Leonardtown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22680 Cedar Lane Court 20650 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant; If item 27 is marked other than ' iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Homer Duke Forester Catherine Lorena Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22776 Three Notch Road Lexington Park, Maryland Frank Goldbach/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If it any injury or o cemetery, crematory or other place)
Charles
orial Gardens 1 X Burial 2 Cremation 3 Removal from State November 22. 4 Donation 5 Other (Specify) Leonardtown, Maryland 2010 21. Si Jaura of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Si Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No s after death 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA AHMED 14

State Registrar 31

31. Date filed (Month, Day, Year)
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BLVD South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov. Day 20 ON BEY 335AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death S HOSPITZU . Mary Leonardtown St. Man If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Days Months Hours Min. Country) Maryland Director Yrs. 83 213-22-0117 July 27, Usual Residence of Deceden 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4836 Hill Road 20636 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was becent ever in 6.3.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 1945 -1965 Black, White, etc. þ 1 Never Married 2 K Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Patuxent River Naval Air Elementary/Seconday (0-12) College (1-4 or 5+) Station 12 Heavy Equipment Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Oscar Starr Gatton Elizabeth M. Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Margaret Janet Gatton / Wife</u> 24836 Hill Road, Hollywood, MD 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State November 24 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 2010 Hollywood, Maryland re of Funeral Service L 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 ar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequ **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 24 hours after death.

Funeral Director: After this certificate 2 No 1 Yes 2 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? <u>1</u>2. Hospital 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) INTERNICI Sideli guMD D562123 11/90/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 PM

DHMH 17 Rev 7/2009

Registrar

Shahid Rafat Siddiqui,

NOV 2

31. Date filed (Month, Day, Year)

M.D..

32. Registrar's Signature

24035 Three Notch Road, Hollywood, MD 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 14:55PM **GAMBER** RONALD в. 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Western MD Regional Medical Center Allegan umber 9 Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 01/27/193 9. Birthplace If Under 1 Year If Under 24 Hrs. **Funeral** Min. 1 🗶 M 2 🗆 F Days Hours 139-24-1811 Director Yrs. 78 Rhode Island Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County e 1 and 2 should be filed within 72 hours after death with the Maryland of health and Mertal Hygiene. The flem 27 is marked other than "natural", or items 23a or 28a-f sho refer 27 is marked other than "natural", or items 25a or 28a-f sho rether traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral Fort Ashby 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral R.R. 2, Box 625 26719 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent 2√5. Armed Forces? 1 X Yes 2 □ No Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Restaurant Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Gamber Edna Mountford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 735 Garrett Avenue, Chula Vista, CA Andrew Gamber Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of I Important: If ite any injury or of 🖵 Burial 2 😿 Cremation 3 🗆 Removal from State Cumberland Crematory 11/12/2010 Cumberland, MD Donation 5 Other (Specify) of Funeral Service L 22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres , or heart failure List only one cause on each line. Approximate Interval Between Onset and Death stoc Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner eumon Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due o (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 No Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At 1 Yes 2 No ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and time of certifier 29d. Date signed (Month. Dav. Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Willowbrook Rd, Cumberland, MD

and address of person who completed cause of death (Item 23a) (Type, Print)

2500

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c,e,f per inf g925 3-16-12 vt #26 per doc State of Maryland / Department of Health and Mental Hygiene State 11-19-10 Registrar Ameno#'s 26, 27, 29c PerPhys, RGCcr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5:49 P M 5, 2010 November Robert Tepper Harrison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6111 Montrose Road #913 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
August 27, 1950 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1**X** M 2□F New York Director 60 133-40-0809 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at Maryland Montgomery Rockville 1 ☐ Yes 2 No Director **Virginia** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Montrose Iron Wil 20852 United States <del>22310</del> Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 X Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lawyer Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othin any injury or other traumatic event once. Be Henry Harrison Clare Tepper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Pitkin-Shantz - Friend 1553 Dominion Hill Court McLean, VA 22101 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens Nov. 9, 2010 Falls Church, VA ature of Furieral Service Licensee 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Drive Alexandria, VA 22315 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home FResidence 6 Home (Specify Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3□ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in

Division or Vital Records,

Hospital or Attending Physician:

this

After

24 hours after deatl Funeral Director:

within 2.

The law requires that the death certificate be executed

physician

P.O. Box 68760,

show

filed within 72 hours after

al Hygiene.

altimore, Maryland 21215-0036

Registrar

Medical

30. Name and advises of person who completed cause of death (Item 23a) (Type, Print)

Ketan Trived: 410 3620 Jusseph Siewick Or St 302 fairfax VP. 31. Date filed (Month, Day, State NOV 1 9 2010

29b. Signature and title of certifie

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0101055841

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marion Rita Henry 2010 10:55 A.M Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 09/09/1924 1 M 2 5 Days Hours Min. 86 **Director** 578-30-6023 Glenarden.Md. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Md. P.G. Capitol Heights 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 505 Suffolk Avenue # 105 20743 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner r 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 11th Postal Service Clerk/GSA U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Clarence Johnson Bertha M. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose P. Elliott/Niece 4503 Bishopmill Cir., Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 11/23/10 Brentwood.Maryland 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. Signature of Funeral Service Licensee acc. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final Physician Fatal Cardiac Arrhythmia disease or condition 15 Mins Medical resulting in death) **Examiner** ≥10 yrs. Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events > 15 yrs Hypertension resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Completed by Physician/Medical Hyperlipidemia >15 yrs Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Pregnant at time of death Day Vear 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Diabetes Type II, History Deep Vein Thrombosis</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? On anticoagulants, Morbid Obesity, Stasis Edema 24a. Was an certificate has autopsy performed? Yes 2 No Hypothyroidism 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 9 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after deaun.

ne Funeral Director: After th 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 2 2 2010

in mamell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leela Kirish namurthy, M.D. 9470 Annapolis Rd. #301, Lanham , Maryland

32. Registrate Signature

29c. License number

D0033503

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physician Madical Examiner    130 Speer Road Chestertown, Maryland 21620	ti. Pag trment rtant: y or o		4 Donation 5 Other Specify: Offesapea.	nter	10/2	5/2010	Chester	Maryland_
Physician Madical Examiner    Part   List only one cause on each line.   Approximate interval some of sying, such as cardad or respiratory arrest, shock, or heart   Approximate interval some of seals inc.   Approximate interval some of seal	Bal Departiment Departiment Impo		21. Signature of Funeral Service Licensee	ellows, Hel	fenbein	& Newn	am Funera	1 Home
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FERMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d.	e,		d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Obstructive Pulmonary Disease, Parkinsons disease  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Obstructive Pulmonary Disease, Parkinsons disease  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Obstructive Pulmonary Disease, Parkinsons disease  Part II. Other significant conditions  Chronic Obstructive Pulmonary Disease, Parkinsons disease  Part II. Other significant conditions  Chronic Obstructive Pulmonary Disease, Parkinsons disease  Part II. Other significant conditions  Chronic Obstructive Pulmonary Disease, Parkinsons disease  Part II. Other significant conditions  Part II. Other significant conditions  Chronic Obstructive Pulmonary Disease, Parkinsons disease  Part II. Other significant conditions  Part II. Other significan	50, te be e sysicia			<del></del>			Lood Date of Late	
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Chronic Obstructive Pulmonary Disease, Parkinsons disease    1   Yes   2   No 3   Probably 4   Unknown	the de ched f	Phy		Linderlying cause give	n in Part I	23e Did toh	pacco use contribute	to the cause of death?
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The state of the s	I Re		25. Was case referred to medical	26 Place of	Death (Check on		No 1	Yes 2 No
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29a. Certifier (Check only one)  29a. Certifier 2  29a. Certifier 2  29a. Certifier 3  29a. Certifier 3  29a. Certifier 4  29a. Certifier 3  29a. Certifier 5  29a. Certifier 5  29a. Certifier 6  29a. Certifier 1  29a. Certifier 6  29a. Certifier 1  29a. Certifier 3  29b. Signature and title of certifier 6  29c. License number 6  October 24, 2010  30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	of ng Ph		27. Manner of Death 28a. Date of Injury 28b. Time of	f Injury 28c. Injury a	t Work? 2	8d. Describe ho	ow injury occurred	
29a. Certifier (Check only one)  29a. Certifier 2  29a. Certifier 2  29a. Certifier 3  29a. Certifier 3  29a. Certifier 4  29a. Certifier 3  29a. Certifier 5  29a. Certifier 5  29a. Certifier 6  29a. Certifier 1  29a. Certifier 6  29a. Certifier 1  29a. Certifier 3  29b. Signature and title of certifier 6  29c. License number 6  October 24, 2010  30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ion trendi feath. tor: /	atio	Natural 5 Pending	1 Yes	2 No			
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29b. Signature and title of certifier  O.C.M.E.  October 24, 2010  Russell Alexander MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	D spital hours meral y fille	Se	4 Homicide					
29b. Signature and title of certifier  O.C.M.E.  October 24, 2010  Russell Alexander MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201	the Ho iin 24 the Fu	ical	(Check only 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date a ation, in my opinion, de	and place, and di	ue to the cause	(s) and manner as s	tated.
O.C.M.E. October 24, 2010  30. Name/and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To T To T	Med	and manner stated.					
30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	15	_	Parl Comment					
Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	+		30. Name and address of person who completed cause of death (Item 23a)	·				
State 31. Date filed (Mogth, Day, Year) 32. Registrar's Signature	Rm			1 Penn Street, Ba	altimore, MD	21201		
TERRE FOR A FIRST I FIN AND A FIRST I FIN AND A FIN HARMENT		ate	31. Date filed (Month, Day, Year). 32. Registrar's Signature	es de		-		

10-08588 L'awrence Nathar	اماما	Please Type of Print in Black Indelible Ink.			egible.	
Lawrence Nathai		Hawkins State Maryland / Department of Heat 1-For State Certificate of Deat Registrar	•	-	Reg. No.2010	37995
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Lawrence Nathaniel Hawkins		2. Date of De Month Novembe	eath Day Year e <b>r 9, 2</b> 010	3. Time of Death 0746 hrs
			v, Town, or Location of Deat trict Heights	th	4c. County of Dear Prince Georg	
Funeral Director		577-94-3997 1XM 2_F 48 Yrs. Mor	nder 1 Year   If Under 24Hr hths   Days   Hours   Min	<b>→</b>	9. Birth(MM/DD/YYYY) 9. B Fore 1962 CIS	inthplace (State or ign every rly, MD
and ishow any	or	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince Georges  Forestville				10d. Inside City Limits 1 X Yes 2 No
e Maryl or 28a-	Director		Zip Code 1747		10g. Citizen of What Con United Stat	-
death with the Maryland or items 23a or 28a-f show must be notified at once.	uneral D	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	dent of Hispanic Ongin? ( S cify Cuban, Mexican, Puert	Specify Yes or N		ncan Indian, Black,
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year 1 1 Yes	2 No specify:			ack
2 hours "natu			al Occupation (Give kind of vorking life. DO NOT use re		16b. Kind of Business	/Industry
5-0036 iled within 7' Hygiene. I other than	ompleted	12 0 Fireman			City Gove	rnment
215-C be filed v ntal Hygi rked oth	Be Co	17. Father's Name (First, Middle, Last) Unknown	18.Mother's Nam Mary H		, Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	ToE	19a. Informant's Name/Relationship (Type, Print)  Stephon Allen / Son  19b. Mailing Addre	ess (Street and Number or a Drive, Dis	Rural Route Nu trict H	umber, City or Town, State	e, Zip Code) 20747
ore, es l and of Heal		20a. Method of Disposition  1		Date	20c. Location - City o	r Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: Maryland Vete 21. Signature of Funeral Service Livensee 22. Name at	erans 11/	30/2010	Cheltenha	m. Maryland
Ba Perm Depri Imp	18	Larry L. Simmons Pope	Funeral Home	, 5538	Marlboro Pi	
Physician Vegical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line. Acute pintine hemor				Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive atheroscle of Due to (or as a consequence of):  b.	otic cardiova	ascular	disease	
	aminer	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ecuted and transit	al Exan	events resulting in death) Last  Due to (or as a consequence of):  d.				
ų ··· , [	edica	☐ AMENDED 23a,27,PII per ME	G910 12/27/10	) TT		
OX ceath or attent for us	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deal 4 Pregnant at time of death 5 Other (S)		ancy	23d. Date of delive Month	ry Day Year
O. B at the d 1 by the	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did	tobacco use contribute to	the cause of death?
S, P.O.  puires that the signed by the detack	ed by	<u>Diabetes; end stage renal disease</u>		1 Ye	es 2 No 3 Pro	utopsy findings available
Division of Vital Records, P.O. B pptal or Attending Physician: The law requires that the doours after death.  Peral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached	Completed			auto perfi 1 🗸 Yes		completion of cause of
/ital sician: is certif	a	25. Was case referred to medical examiner?  Hospital: Inpatient 2 ER/Outpatient 3	26.Place of Death (Check		Residence 6 🗸 Othe	er: Scene
on of Vending Physath.  Or: After the funeral of	tion: To	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	28c. Injury at Work?		e how injury occurred	
Divisior Hospital or Attend 24 hours after death. Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factor (Specify)	ory, office building, etc.	28f. Location or Town,	(Street and Number or R State)	ural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at to the basis of examination and/or investigation, in and manner stated.				
	Ň		9c. License number O.C.M.E.		November 10, 2	
44		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 2120	)1		
Sta	ate rar	31. Date filed (Month, Day Year) 32: Registra's Signapre				
	_					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HUMPHRE Physician/ Month Day > Medical ZeYO 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4002 KINGSFAIR COURT PRINCE GEORGE'S BOWIE Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 1931 **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Director  ${f AUGUST}^{(Month,\;Day,}$ FLORIDA 578-58-7733 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Iral", or items 23a Examiner must b 4002 KINGSFAIR COURT 20721 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ DEPUTY SUPERTENDENT GOVERNMENT Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) WILLIAM EVANS ETHEL CAMPBELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM HUMPHREY JR./HUSBAND 4002 KINGSFAIR COURT BOWIE, MARYLAND 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN CEMETERY 11/19/2010 BRENTWOOD, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL ROME . Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Immediate Cause (Final Driset and Drigth Physician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director, After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 은 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined hours after within 24 hours a

To the Funeral I

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2010

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32. Registra

s Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARTHA HUBBARD Medical 2010 7:45 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 307 WHITETAIL DRIVE DUNKIRK CALVERT 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X F Months Hours Min (Month, Day, Ye **Director** Country) MARYLAND 579<u>-32-7785</u> Usual Residence of Deceden 28a-f shov 10a. State with the Maryland notified at 10b. Counts 10c. City, Town or Location Director 10d. Inside City Limits CALVERT DUNKIRK XX Yes 2 □ No ō 10e. Street and Numbe 10f. Zip Code Examiner must be 10g. Citizen of What Country? Funeral items 23a 307 WHITETAIL DRIVE 20754 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 'n, þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: "natural", Completed 3 Widowed 4 Divorced Specify: CAUCASIAN Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 than Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other tha lury or other traumatic event, the N College (1-4 or 5+) 10TH BHYER RETAIL STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY STALLINGS HATTIE SEARS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE PRICE/GRANDSON permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 12171 CAVALIER DRIVE DUNKIRK, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL 11/18/2010 SUITLAND, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MARSHALL-MARCH FUNERAL HOME Ma 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ 27 broves disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Daile to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit executed resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month 2 No the g Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Hospital Other: 2.00 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Statement 6 Other (Specify) : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No I Director: A Accident Investigation Suicide 6 Could not be thin 24 hours after do the Funeral Director mpleted filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Pragtioner: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10845 TOWN CENTER BLVD. OSUITE 204 DUNKIRK, MD 20754

State Registrar 31 Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MARK DONNELL HANKINS 03:26 AM Medical 0100 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🙀 M 2 🗆 F (Month, Day, Yea 1 / 4 / 1 9 5 9 Months Days Hours Min Director 579-84-7364 Washington. DC Usual Residence of Decedent 28a-f shor notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 🗆 No Prince George's Maryland Landover ь 10e. Street and Numbe 10f. Zip Code Examiner must be 10g. Citizen of What Country? 23aFuneral 906 Hill Road # 201 20785 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Yes 2 No If Yes, Give ò þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: "natural" Completed 3 ☐ Widowed 4 ☑ Divorced Specify. Year or Dates **Black** Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Truck Driver Private Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>ی</u> permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Carson Lee traumatic Hankins Dorothy Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilly Hankins / Sister 906 Hill Road # 201 Landover, \_Maryland\_ 20785 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Harmony Memorial Memorial 11/15/2010 | Landover, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. MOLDIS 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lavel Medical Due to (or as a consequence of): Examiner neumomon Sequentially list conditions, if any leading to immediate Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Interstitial and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atte in the past 12 months? Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No မှ Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🙀 Naturai 5 Pending ours after death.

neral Director: Aft
filled in by the fur Accident
Suicide Investigation 1 🗌 Yes 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 3001 Hospital Drive

00042185

Cheverly, Maryland 20785

Karen R Brooks

Karen R. Brooks M.D.

7 2010

31. Date filed (Month, Day, Year

NOV 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ P.M 2010 5:20 Donald Thomas Howard November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospice of St. Mary's Callaway 8. Date of Birth (Month, Day, Ye March 14, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Hours Florida 267-54-7403 71 Yrs Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director 1 Yes 2 No St. Mary's California Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 20619 22648 Parkview Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry United States Elementary/Seconday (0-12) College (1-4 or 5+) Government Program Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ Lucille Amanda Arnold permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Charles Jefferson Howard other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22648 Parkview Drive California, Maryland Leilani Pearl Howard/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date November 18 1 Burial 2 Cremation 3 Removal from State Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 2010 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immedia cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2 To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number Signature and title of certifier 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Point Lookout Road Leonardtown, Maryland 20650 25365 William . 31. Date filed (Month, Day Year) William D. Boyd State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mona Lee Hymes 1830 Ρ Novembe 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Health Nursing & Rehab. Center Cumberland Allegany If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Months Days Hours 05/21/1934 Pennsylvania **Director** 219-34-6033 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Cumberland Allegany 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21502 Funeral 730 Furnace Street within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2**X** No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give and Mental Hygiene. 3 X Widowed 4 Divorced White Year or Dates. traumatic event, the Medica 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Aide Public Schools Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othv any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth ပ Rolan Earl Emerick Nellie Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7223 Lincoln Highway, Thomasville, PA Mark A. Hymes / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State Cumberland Crematory 11/16/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Sign Jury of Funeral Service Lizensee Adams Family Funeral Home, 22. Name and Address of Facility 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) telerio Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine Date to for an a connectioner off cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Pregnant at time of death 5 Other (specify) the 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy nerform death? certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? 2 🗹 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this o 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation within 24 hours after death

To the Funeral Director; A
completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jr., 200 Glenn Street, Sute 302, Cumberland, MD 21502 Robustiano J. Barréra, M.D.,

Registrar

State

31. Date filed (Month, Day, Year) NOV 16 2010

32. Registrar's Signature